Official Publication of the
MEDICAL AND CHIRURGICAL FACULTY
OF THE STATE OF MARYLAND

LUTHERAN HOSPITAL ISSUE

Maryland

STATE MEDICAL JOURNAL

VOL. 4 NO. 7
July, 1955

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1211 CATHEDRAL STREET, BALTIMORE 1, MARYLAND

Official Publication of the Medical and Chirurgical Faculty of the State of Maryland

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THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND
Secretary's Office, 1211 Cathedral Street, Baltimore, Maryland

Entered as second-class matter at the Post Office at Baltimore, Md. Acceptance at the special rate authorized

Single Copies, 50¢ *Subscription $3.00 per year*

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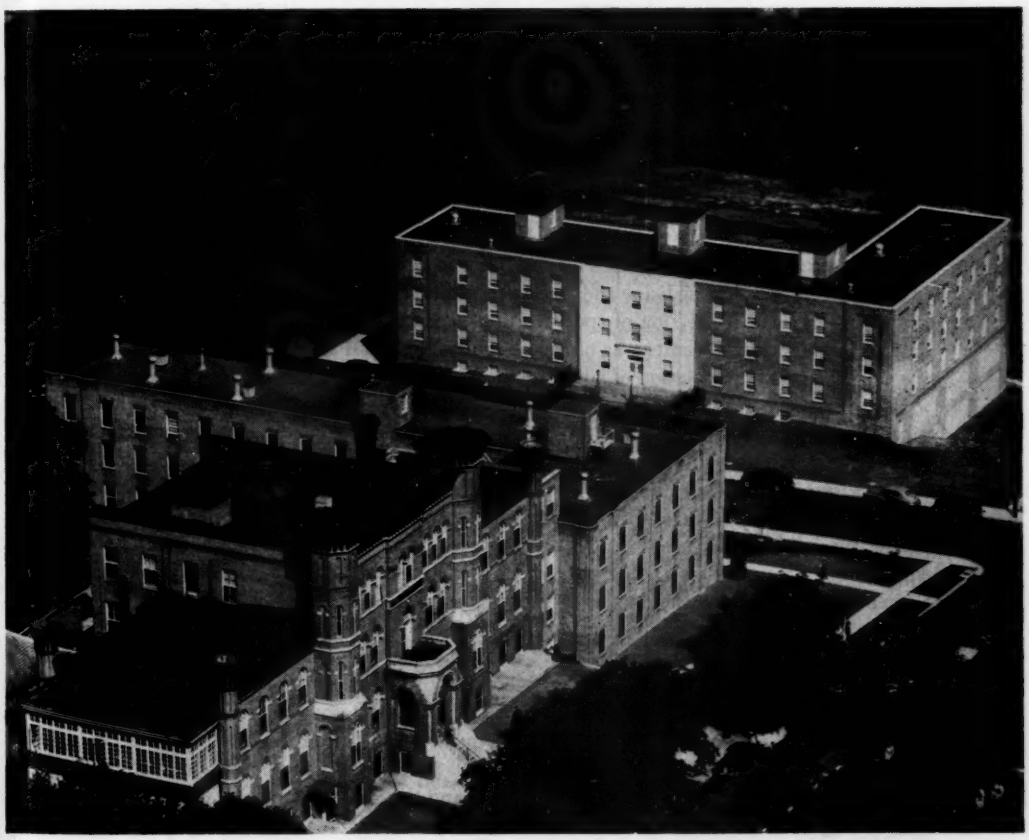
Maryland
STATE MEDICAL JOURNAL
Medical and Chirurgical Faculty of the State of Maryland

VOLUME 4 | *July, 1955* | NUMBER 7

LUTHERAN HOSPITAL OF MARYLAND ISSUE



THE LUTHERAN HOSPITAL OF MARYLAND

EDITORIAL

LOUIS KRAUSE, M.D.*

In the middle of the last century the ground occupied by the Lutheran Hospital was part of a large tract of land used by Baltimore City for its second Alms House and Hospital. In 1872 after the City relocated its Alms House, Mr. William S. Rayner bought and presented to the Hebrews of Baltimore the old City Alms House for an Orphan Asylum, valued at $50,000. At the dedicatory service of the orphanage, the Rev. Dr. Szold offered a fervent prayer. Rev. Szold was the father of Henrietta Szold of Zionism and Israeli fame. Interesting that this building later became the West Baltimore General Hospital in 1924—eventually the Lutheran Hospital.

This West Baltimore General Hospital slowly grew in spite of the many difficulties in its path. After a few years the institution became a successful hospital. The staff was an enterprising group with faith in themselves and a devotion to the ideals of modern medicine. The necessity of maintaining and improving professional competence was always in their mind. This group organized the Interne Alumni Society which has been one of the vital components of the hospital. The frustrations and the experience common to all in the practice of medicine were the common bond keeping the staff together and on the road to higher things.

In the late 1940's, the Lutheran Church of Maryland was considering building a hospital for the chronically ill or an Aged Home. Eventually, in 1950, the West Baltimore General Hospital was acquired by the Lutherans and the Lutheran Hospital came into being. This gave recognition to the worth of the West Baltimore General Hospital, while at the same time, contributing to the material and spiritual prestige of the institution. Since then, the Lutheran Hospital has been growing in stature, physically, mentally and spiritually.

Looking back over the years, it is apparent that the devoted and loyal personnel could not create perfection but they did the best under the circumstances. To paraphrase Trousseau, they not only recognized disease but also sick people.

Today, how complex medicine and medical education is! In recent years, the pendulum has swung far in the direction of specialization—specialists who can perform their work only in the big medical centers, as of course it should be, but this often tends to deprive the smaller areas of population of adequate medical care. Happily, efforts are being made today to improve and provide better medical care in smaller towns. The Lutheran Hospital fortunately includes on its staff not only specialists but a goodly number of general practitioners. With the understanding of the patient and his problem, including his domestic and social environment, the family doctor can exercise his talents in a favorable atmosphere in the hospital. The family doctor, who knows his limitations, has available competent specialists when needed. The doctor must have the ability of a scientist, the warmth of human understanding, and a sense of consecration. When patients entrust their lives and health to the doctor, he must remember he is dealing with folks, who by reason of the very nature of their infirmities, often are bewildered. They turn to him not only for professional advice, diagnosis and treatment, but for that human understanding, sympathy and compassion that will enable them to face their problem with courage. Patients are comforted when they know that the sympathy and the compassion offered arises from deep within the doctor's soul. This quality results from the doctor's consecration. The dedication on the part of the doctor will never permit the practice of medicine to become a business. This devotion to humanity and the ideals of medicine is comparable

* Chief, Medical Department.

in every way to the heights of real religion as expressed by Job ca. 400 B.C. "Doth Job fear God for nought." The answer must be and is unequivocably, "Yes," in medicine or religion. Medicine is no better than the individuals who practice it! Now, as in the past, the physician as any other worker, must work. The general attitude about us today is that the less work one does, the better off society will be. Idleness and spending can never replace working and saving.

A future is always assured in medicine. This was so well implied in Job ca. 400 B.C. "All that a man hath will he give for his life." As Bacon so succinctly wrote, "For the vexations of sickness, the sweetness of life, the flattery of hope, the commendations of friends, maketh men to depend upon physicians with all their defects." Bear in mind, the medical practitioners like any other group are made up of human beings with the same inherent fine qualities and weakness of their fellow men.

For that reason the doctor must in humility recall his errors in judgment and otherwise, and ask the:

"Eternal Potter! whose blest hands did lay
My coarse foundation from a sod of clay,
Thou know'st my slender vessel's apt to leak,
Thou know'st my brittle temper's prone to break.
Are my bones brazil or my flesh of oak?
O mend what thou hast made, what I have broke:
Look, look with gentle eyes, and in thy day
Of vengeance, Lord, remember I am clay."

We hear so much about the atomic age that we are led to believe that a new era is being ushered in, in which all of our old concepts of eternal truths are of no avail or not valid. It is true that "time makes good uncouth." But it is equally true that new conditions beget new duties, and these require more of the old moral responsibilities. With these new obligations, we have only to become familiar with the tools. Most of us will continue to translate into terms of human relief and alleviation from suffering, the contributions from clinical and laboratory research—Today we discover our errors of yesterday, and tomorrow we may obtain a new light on what we thought ourselves sure of today. One needs only to think of the diseases that are curable today and those that are preventable. Now we must ask the question—in all humility—How are we doing? Self evaluation and self improvement have always been a real part of the practice of medicine and the medical profession. Our conscience in addition to the pressure of competition makes us work harder and harder. Our compassion and integrity become our severest judge. Can we satisfy both our head and heart? It is this that we are striving to do, providing satisfactory medical care. Like poor medical education, unsatisfactory medical care is so expensive both in material and human life. Efforts to present this concept are made daily in the teaching that now is so much emphasized. The impact of a teacher on the student is not so much what he says as what he does, the example set.

The practice of medicine in all good hospitals is really the modern application of Jesus' parable of the Good Samaritan. The essential driving force must be the compassion of the Good Samaritan. This human attribute is the most important necessity. This must be common to every one on the hospital roster. The medical, nursing and technical staff represent the Good Samaritan. The administration and other personnel typify the Inn Keeper and the Inn. The Board of Trustees represents the source of the Good Samaritan's "two pence and whatsoever thou spendest more." With Nehemiah, they may say, "Think upon me, my God, for good according to all that I have done for this people." The Good Samaritan, who, bound by no formalism, rose above race, color, and creed, is still living in

every doctor, who "ever beholds in the afflicted and suffering only the human being, a child of God." *May his tribe increase as expressed by Leigh Hunt:*

Abou Ben Adhem (may his tribe increase!)
Awoke one night from a deep dream of peace,
And saw within the moonlight in his room,
Making it rich and like a lily in bloom,
An angel writing in a book of gold:
Exceeding peace had made Ben Adhem bold,
And to the presence in the room he said,
"What writest thou?" The vision raised its head,
And with a look made of all sweet accord,
Answered, "The names of those who love the Lord."
"And is mine one? said Abou. "Nay, not so,"
Replied the angel. Abou spoke more low,
But cheerly still; and said, "I pray thee, then,
Write me as one that loves his fellow-men."

The angel wrote, and vanished. The next night
It came again, with a great wakening light,
And showed the names whom love of God had blessed,—
And lo! Ben Adhem's name led all the rest!

11 East Chase Street
Baltimore 2, Maryland

Special Article

LUTHERAN HOSPITAL OF MARYLAND

ROBERT S. HOYT[1] AND ROBERT D. STOUT[2]

The Lutheran Hospital of Maryland is located on a plot of ground which has filled a community need in the Baltimore Area for more than 130 years. Shortly after the turn of the 19th century the metropolitan area of Baltimore was becoming crowded. The Baltimore City and County Alms House, which was located on Howard Street in an area now used for the Richmond Market, was moved to the "country." This was "Calverton" the former home of Mr. Dennis A. Smith, which is the present site of Lutheran Hospital. As the years went by the city moved toward this location and once again it was decided to move the Alms House.

Isadore Rayner purchased the abandoned Alms House Buildings and part of his philanthropic work was to make this property a gift to the Associated Jewish Charities in 1872. This organization established the Hebrew Orphanage which began its charitable work that same year. A fire destroyed most of these buildings a few months later and the following year a large new building was erected. This building later became the major building of the Hospital.

About 1910, Associated Jewish Charities adopted the principle of "foster homes." The buildings stood idle until early 1923 when renovation began for conversion to the West Baltimore General Hospital.

West Baltimore General Hospital was organized in the area known as South Walbrook, which, by this time, had grown to a population of approximately 100,000 people. These people were located in an area which heretofore had been somewhat neglected from the standpoint of hospital care. The original challenge, as set forth in the *Baltimore American*, of June 8, 1924, was that "this hospital was born in a neighborhood in need, and would provide care for the man of moderate means." It planned to establish at the outset, in addition to the hospital, an out patient department, a three year training school for nurses, and a one year course for practical nurses.

Many notable people gathered with the physicians and businessmen of West Baltimore, who were the sponsors of the organization, for the grand opening on June 12, 1924. They included Judge Jacob M. Moses, who was in charge of the occasion, and, the then, Governor Albert C. Ritchie; Mayor Howard W. Jackson; former Governor Phillips Lee Goldsborough; Dr. Joseph Bloodgood; and Dr. C. Hampson Jones.

The original medical staff was composed of 145 physicians, headed by Dr. Arthur G. Barrett. They were assigned to the following services: general practice; surgery; medicine; obstetrics; gynecology; chest; urology; gastro-intestinal; nervous diseases; mental diseases; preventive medicine; pathology; laboratory; X-ray; eye, ear, nose and throat; dermatology; and dental surgery.

A number of prominent citizens made up the original Board of Directors. These were: Victor G. Bloede, President; Com. Thornton Rollins, Vice President; John H. Duncan, Treasurer; James T. Vernay, Secretary; Bernard Moses, Charles R. Klosterman, John Freund, Solomon Mendols, William G. Albrecht, C. Oscar Benedetti, Leon W. Himmel,

[1] Administrator.
[2] Assistant Administrator.

Jonathan K. Voshell, Irving C. McCormick, William H. Thomas, John J. Hanson, J. Francis Hock, P. J. Lavelle, Henry Bucksbaum, Douglas Thomas, W. E. Scheer, J. P. Dugan. One of these members, Mr. Irving C. McCormick, is an active member of the present board, and has served in the capacity of Secretary to the Board for thirty years.

The first patient came into the accident room for admission during a harp solo in connection with the opening ceremonies. According to records retained by the Medical Records Department, this twenty-five year old female delivered an eight pound baby girl a few hours later.

Thus, the newly renovated hospital of approximately one hundred beds and twenty bassinets began a career which saw many hardships due to financial crises and changes in medical staff, organization, and constitution.

The early records of the Board of Directors reveal that the daily room rate was $3; however, in 1925 it was decided that this rate was excessive, and it was reduced to $2.50. In the early days the Board of Directors felt the hospital was meeting a real community need because an average of nineteen patients were listed on the daily census sheet and the operative schedule averaged two patients.

In 1926, a nurses home was constructed on the Lanvale Street side of the property in order that the students in the school of nursing could be housed in a single building. This building, today, is used by the hospital for other purposes.

From the original census of nineteen patients in 1925, the hospital became an institution dedicated to full utilization by 1939. At times more than one hundred beds and twenty bassinets were used and with medicine advancing at a rapid pace, plans for expansion of services and beds began once more.

The advent of World War II caused a rapid expansion of Baltimore and particularly of the western sector of the city. Construction of most civilian projects was cancelled, but, by this time, the need for expansion of hospital facilities had become so acute that monies appropriated by the Federal Government, through the Lanham Act, were made available to build several additions to the hospital. The first of these was a building to house the steam plant and laundry. This construction was completed in 1941. Following completion of this building, a new one hundred bed wing was constructed and put into operation in January, 1944. A new nurses home was completed in 1945. This building program was consummated at a cost of more than $1,000,000.

The original building was again renovated in 1944, and ancillary services were expanded in it which reduced the capacity in this wing to sixty-five beds. The hospital then continued operations in this new phase at its present capacity of 191 beds and forty-three bassinets.

Immediately following the Second World War it was generally agreed by members of the Board of Directors that community hospitals needed support from organized charitable groups. This need resulted both from a financial and a spiritual standpoint. The Board began to interview various groups that had expressed an interest in hospitals. The Lutheran Churches had a definite desire to enter the hospital field as their program of community stewardship expanded.

The Lutheran Home and Hospital Association was organized in 1947 as a cooperative agency to represent the Lutheran Churches in the hospital field. This group's first objective was to establish a chronic disease hospital in the area of White Marsh, Maryland but due to the distance from the city, it was agreed that the location was not suitable. The Association then entered into negotiations which resulted in an agreement to sponsor the West Baltimore General Hospital as a church related institution to be known as the Lutheran Hospital of Maryland.

The formal ceremony of dedication took place on July 9, 1950, at which time, the West Baltimore General Hospital officially became the Lutheran Hospital of Maryland. The

Lutheran Home and Hospital Association established a trust fund from which the hospital has the right to draw a set amount each year for retirement of debt, improvements, expansion, and replacement of equipment. It was agreed, as part of the merger, that members of the Lutheran faith would be placed on the Board of Directors until the majority of the group was composed of members of that faith.

Although under church auspices, the Board of Directors, the Hospital, the School of Nursing, and the Graduate Medical Education Programs serve people of all faiths as the hospital continues to render its service to all those in the community who are in need. An open staff medical policy has obtained for the hospital, a staff of excellent physicians who firmly meet the challenge of medical care, education, and research.

A renewed vigor, resulting from a compassion for the less fortunate, and a practical generosity which is typical of the Lutheran Churches, has resulted in many improvements to the facilities, and has provided a productively progressive impetus to the furthering of the educational and research programs of the hospital.

The three-year diploma program in nursing education is approved by the Maryland State Board of Examiners of Nurses and the Maryland State Department of Education. It is accredited by the National League for Nursing Accrediting Service under the five-year plan of temporary accreditation.

The Postgraduate Education Program in Medicine is approved for training of interns, and residencies in Medicine, Surgery, Pathology, Obstetrics and Gynecology. The Hospital is accredited by the Joint Commission on Accreditation of Hospitals, is a member of the American Hospital Association, the Maryland-District of Columbia-Delaware Hospital Association, Lutheran Hospital Association, and the American Protestant Hospital Association. It is a charter member of the Maryland Hospital Services (Blue Cross) and The Hospital Council.

Following the criteria of the original founders of the Hospital who were concerned about "the man of moderate means," the hospital has done everything possible to make itself available to these people. In January 1947, it adopted, for all accommodations other than private rooms, the principle of inclusive rates for charges to patients for the service which it renders. While all hospital costs are high, because of tremendous advances of modern medicine, and an increasing need for larger staffs and expensive equipment, this system of charging patients enables the hospital to guarantee that the bill will be no more than an amount stated at the time of admission. It makes it possible for the hospital to make available all of its facilities to each patient at a minimum cost.

By 1949 the hospital was again experiencing the problems of inadequate space to carry the responsibility placed upon it by its community. Each year this demand increases, and today it has become obvious that an acute need again exists for further expansion.

In the year 1954, the Hospital admitted 10,439 patients, cared for 2,689 newborns, rendered 68,474 days of patient care to inpatients and cared for 12,001 patients in the accident room and had 8,850 visits in the out patient department.

Positive steps toward additional expansion are underway. Preliminary plans for construction designed to alleviate immediate needs, and to foresee future demands are under consideration by an architectural firm. It is the aim of the Board of Directors, who have for many years devoted hours of tireless efforts to this Hospital, that, one day, The Lutheran Hospital shall stand as a 350 bed unit which effectively meets the needs of the community which it serves and which so conscientiously supports it.

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Scientific Papers

PILONIDAL DISEASE

WILLIAM E. GILMORE, M.D. AND HAROLD L. DALY, JR., M.D.*

Considerable interest in pilonidal disease was stimulated by the recent war, and the literature on this subject has increased tremendously over the past ten years. Interest was centered primarily on the various methods of closure, after excision, with an evaluation concerning the rate of recurrence and the length of hospitalization. The military aspect was, of course, emphasized, and the speed with which a man could be returned to duty was the primary objective.

Today, in civilian practice, there is still no uniformity of opinion concerning the most satisfactory type of operation. Numerous variations of both the open and closed methods can be found described in the literature.

It is our purpose to report on the treatment of pilonidal disease and results obtained in recent years at a small, non-teaching hospital and to discuss briefly the history of the disease and the current ideas concerning its cause.

During the past seven years at the Lutheran Hospital of Maryland there have been one hundred and five patients treated for pilonidal disease by surgical excision. Not included are numerous cases of incision and drainage for pilonidal abscess in which no attempt was made to remove the lesion. Of those treated by some type of surgical excision, a follow-up study was possible in seventy-two cases, and it is with these that our report concerns itself. The ages varied all the way from fourteen to seventy-two years, although the great majority of patients were in their late teens or twenties. There were fifty-two males and twenty females, a predominance of more than two to one, which is in agreement with other reports.

* From the Department of Surgery.

The so-called "open" method, in which no attempt was made to approximate the wound, was employed in twenty-two operations and the remaining fifty were closed either with or without drainage. There were eleven failures following the seventy-two operations representing an overall recurrence rate of fifteen per cent. No significant difference in the frequency of recurrence was noted between the open and closed methods. Pathological examination of the removed specimens showed hair to be present in fifty-four cases, or seventy-five per cent. The remaining eighteen cases, although they showed no hair grossly or microscopically, were, clinically, typical pilonidal sinuses.

Type of Repair	Number of Cases	Number of Recurrences	Per Cent Recurrence
Open	22	3	15%
Closed	50	8	15%
Total	72	11	15%

What is probably the earliest description of a pilonidal sinus may be found in the Boston Medical and Surgical Journal of 1847 by A. W. Anderson[1] under the title "Hair Extracted From An Ulcer." It is interesting to note that this ulcer, which was situated over the coccyx failed to respond to the usual treatments of the day, but healed promptly after removal of a loop of hair from its depths.

Warren[2] in 1867 gave a detailed description of a pilonidal sinus and also offered a theory as to its origin. He believed that the hair became inverted in its follicle and, growing in a reverse direction, produced a hair filled dimple or tract.

The term "pilonidal," which means literally "nest of hair" was first used in 1880 by Hodges[3] to designate a hair-containing sinus over the sacro-coccygeal area. He felt it was caused by body hairs that insinuated themselves beneath the skin in pre-existing sacral dimples forming infected sinuses with foreign body reaction and granulation tissue.

By the turn of the century a great deal of study and research had been carried out on the subject, not only abroad but in this country, and the disease was generally considered to be congenital in origin. Notable among those whose work contributed to our knowledge of the disease at this period were Tourneux and Herrmann,[4] Mallory[5] and Fere.[6]

Differences of opinion existed, however, even at this early date. Some thought the sinuses represented a persistent remnant of the neural canal, whereas others believed them due to an abnormal development with down-growth of the surface epithelium.

In 1924, Stone,[7] in discussing the etiology of the disease, felt that it was the result of a down-growth of the surface epithelium due to an unknown cause. In 1931, however, he[8] suggested that this down-growth represented a structure analogous to the preen gland found in birds.

In 1935, Gage[9] published a detailed anatomical study of the disease, and concluded that pilonidal cysts "are the result of embryologic developmental defects occurring in the caudal end of the neural canal." He distinguished between true pilonidal cysts, or sinuses and sacro-coccygeal dimples, which may also form a cyst or sinus but are caused by an "anomalous development of the caudal ligament and its attachment to the skin."

An excellent paper in 1942 by Kooistra[10] reviews the entire subject and presents substantial evidence, in the form of serial sections on human embryos, supporting the congenital theory. Although he believed the cause to be definitely congenital, he felt there was not sufficient evidence to indicate whether the anomaly was derived from skin or from the neural canal. In evaluating the surgical treatment of the disease in a series of eighty-nine cases he found a twenty-two per cent recurrence rate following the open method, and a twenty-eight per cent recurrence following the closed method of repair.

In contrast to a congenital theory of origin, Patey and Scarff[11] and Gifford[12] have suggested the possibility that the sinuses are traumatic in nature. They describe typical pilonidal sinuses involving the webs between the fingers of barbers presumably caused by penetrating hairs, and they believe the same mechanism is responsible in the sacro-coccygeal area. It is interesting to note the similarity of this theory with that offered by Hodges when he first named the disease in 1880.

In trying to evaluate the different theories, one finds seeming contradictions in all. If the lesions are of congenital origin, why are they so difficult to remove successfully, and why such a relatively high rate of recurrence or persistence? Thyroglossal duct and branchial cleft sinuses or cysts are unquestionably congenital in origin and are also often infected. Their recurrence rate after operation, however, is much lower and an extensive block type of excision is not usually required.

Confronted with a recurrence shortly after a radical en bloc excision, the surgeon sometimes finds it difficult to place the blame on a remnant of tract left behind. One of us recently reoperated upon one of his own patients with a recurrent pilonidal lesion on which only six months earlier he had done an extensive excision. At the second procedure the operator was surprised to find not only a large tract at the same location as the previous one, but also considerable hair in the same region. It is certainly possible that some parts of the tract could have been left behind at the first operation, but it is difficult to believe that a large hair-containing sinus could have been missed.

On the other hand, if the sinuses are traumatic and result from broken hair shafts working their

way beneath the skin, why do they occur so frequently in one location, namely the sacro-coccygeal region? A few isolated reports have been made of similar lesions occurring in the perineum and axilla; and, of course, Patey and Scarff[13] and Joseph and Gifford[14] have shown their presence in the inter-digital webs of barbers. Hodges, who first proposed this explanation in 1880, assumed the presence of a sacral dimple which acted as a trap to catch the hair that eventually produced the sinus. The navel is notorious as a waste-basket for all types of body debris including hair and yet it has not been reported as the site of a pilonidal lesion.

What are the outstanding facts in any large series of pilonidal cases, and do they shed any light on the pathogenesis of the disease? One of the most constant features is the appearance of the lesion during or shortly after adolescence. We believe this tendency to occur at the time of development of the secondary sex characteristics favors a congenital origin.

A second observation which stands out in reviewing any large number of these cases is the definite preponderance of males. If we assume no sex differential for congenital anomalies, then the factor of increased hirsutism in males may be significant and would indicate an acquired rather than congenital cause.

The third and perhaps most striking features in any series of pilonidal cases is their tendency to either persist or recur after even wide surgical excision. Although this fact may not necessarily have any bearing on the etiology of the disease, it would seem reasonable to assume that the same factor that caused the original lesion was also responsible for its recurrence.

Another interesting observation about the disease is its scarcity in the negro. Does this represent a racial characteristic or is it related to the relative lack of body hair in that race?

In our present state of knowledge conclusive proof in favor of either the congenital or acquired theories is lacking, and not one of the proposed theories can satisfactorily accommodate all of the peculiar aspects of this disease.

SUMMARY

The results following surgery in seventy-two cases of pilonidal disease are presented.

The over-all recurrence rate was fifteen per cent and there was no significant difference in result between the open and closed method of repair.

A brief history of the disease is outlined and various theories of etiology are discussed.

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INDICATIONS FOR HYSTERECTOMY

A Survey of 1000 Cases*

JAMES L. GRAY, M.D.,† AND URSULA T. SLAGER, M.D.‡

INTRODUCTION

Indications for hysterectomy are not only extremely controversial, but vary in different sections of the country and with individual gynecologists. Although the basic concepts underlying these indications have remained unchanged, the steadily declining morbidity and mortality incident to hysterectomy has affected the frequency and type of hysterectomy acceptable in hospital practice. Subtotal hysterectomy is now rarely done in the major gynecological clinics, the reported incidence being less than 5 per cent.[1] The advent of chemotherapy and antibiotics, blood banks, improved anesthesia, and better training for gynecologists and surgeons has made total abdominal hysterectomy a more frequent and safer procedure. Somewhat similar factors have also created an increased enthusiasm for vaginal hysterectomy. With the increasing safety and technical facility of hysterectomy, a careful analysis of the indications for this operation is needed to obviate what might be considered by some a hasty decision to operate. Hysterectomy, like orchidectomy or mastectomy, is still not considered a prophylactic procedure and should only be performed for certain very definite indications.

Very few critical analyses of actual clinical practice are available in the literature. In 1946, Miller[5] analyzed the hysterectomies performed in ten different hospitals of varying sizes, located in three midwestern states. He found that there was either no disease, or disease contraindicating major surgery, in 33.1 per cent of the cases reviewed. Marshall[4] reported that 12.5 per cent of the hysterectomies performed over a ten year period in a small general hospital in British Columbia were done without sufficient cause and yielded normal uteri. There was an additional, almost equal, number of uteri removed from patients who had no symptoms, or whose complaints could not be ascribed to the minimal amount of disease present. In 1947, Bieren and Hundley[2] reported on 300 normal uteri removed during the course of 1,701 hysterectomies at the University Hospital, Baltimore, Maryland. They found that 2.5 per cent of the 300 uteri were removed without indication. Unfortunately, emphasizing the removal of a normal uterus, they did not state how many of the hysterectomies, although not indicated, yielded uteri with minor lesions of no pathological significance.

Emphasis should thus be on the indications for a hysterectomy, based on the clinical as well as the pathological findings. Hence, the clinical practice was analyzed in a small-open staff teaching hospital.§

It was hoped that the results of such a survey would be helpful in the evaluation and treatment of the many gynecological patients with constant vague, ill-defined complaints and equivocal physical findings who so frequently plague the physician. Three concepts should emerge from this survey. First, the unequivocably acceptable indications for a hysterectomy; second, certain repeated mistakes in practice or judgment which, once ascertained, should be avoidable in the future; and lastly, certain protocols to serve as a

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§ The Lutheran Hospital of Maryland. Statistics for 1954: Bed capacity: 191 beds and 43 bassinets; total admissions: 10,439; total operations: 3,426; total surgical specimens: 2,221; total gynecological procedures: 1,671.

guide to the practicing physician in those vague circumstances in which the indications for hysterectomy are, at present, ill defined.

METHODS AND MATERIALS

One thousand hysterectomies performed at the Lutheran Hospital, covering a seven year period from February, 1948, through January, 1955, were reviewed. As far as possible, the uteri were classified according to pathological findings. If the pathological findings were considered sufficient to warrant hysterectomy, the operation was considered indicated, even though the pre-operative diagnosis was inaccurate. Similarly, if the clinical signs, symptoms, and history of the patient were such as to warrant hysterectomy, the procedure was considered indicated even though the uterus was normal. Where any doubt existed about the indications for the hysterectomy after careful review of the clinical charts, the cases were submitted independently to two additional observers, one a pathologist and the other a gynecologist. Hence, the hysterectomies here reported as non-indicated were so judged by four independent observers.

RESULTS

A tabulation of the frequency of the various indications for hysterectomy in the series is given in Table 1. From this, it can be seen that myoma accounts for slightly over ¼ of the cases, adenomyosis and prolapse are respectively next in frequency, and the fourth most common group is the non-indicated hysterectomy. The criteria for inclusion in each group, and an analysis and clinical correlation for each group are given below.

TABLE 1

Incidence of Indications for 1000 Hysterectomies

Indication	Per Cent
Myoma	26.0
Adenomyosis	14.8
Prolapse	14.4
Pelvic Inflammatory Disease	10.4
Endometriosis	3.8
Ovarian Tumors	3.8
Malignancy, Corpus Uteri	3.3
Malignancy, Cervix Uteri	3.3
Dysfunctional Bleeding	3.0
Obstetrical Indications	2.4
Miscellaneous	2.5
Not Indicated	12.3

Myoma

The myoma is the most common indication for removal of the uterus, both in this and other series.[4, 5] It is an extremely common neoplasm, being found at autopsy in 20 per cent of women over 30 years of age.[6] In the majority of these it produces no symptoms, so that the presence of a few small myomata is per se no indication for hysterectomy. Hence, the following criteria were established.

All submucous myomata, regardless of size, constituted a definite indication for hysterectomy. (Sixty-nine of the 260 cases, or 26.5 per cent fell into this group.)

Intramural and subserous myomata were considered of no pathological significance unless they fell into the following categories: 1. A single large mass of sufficient size to distort and displace the uterus and to rise out of the pelvis. No age differentiation was employed, although it should be emphasized that myomectomy is too rarely used in these circumstances. 2. Multiple smaller masses which collectively increased the size of the uterus to at least that of a pregnancy of three months gestation. 3. Sudden rapid increase in size, a condition not encountered in the cases reviewed here. One hundred ninety uteri, or 73 per cent, were found to have such intramural or subserous myomata. One additional case had a large intraligamentous myoma which could not be removed without concomitant hysterectomy.

The pre-operative diagnosis was made in 250 of the 260 cases, an accuracy of 96 per cent. Of the remaining 10, eight were submucous myomata variously diagnosed as adenomyosis, functional bleeding, and endometriosis, and two

were large myomata misinterpreted as ovarian cysts.

Adenomyosis

This was the second most common pathological finding, accounting for 14.8 per cent of the hysterectomies. The condition was considered an indication for hysterectomy, no matter what the pre-operative clinical diagnosis, with one exception. It is of interest, that incidental adenomyosis was found in 10 per cent of the uteri removed for prolapse, 13 per cent of those removed for pelvic inflammatory disease, and 10.5 per cent of those removed because of ovarian lesions.

Clinically, this presented one of the most difficult diagnoses. The correct diagnosis was made pre-operatively in forty-nine cases, an accuracy of 33 per cent. Most of the patients came to operation before the typical findings of an enlarged, fixed uterus with irregularity of the utero-sacral ligaments had fully developed. The most common error was the diagnosis of myoma, made in sixty-six (45 per cent) of the cases.

Prolapse

The treatment of procidentia depends on such factors as the degree of the prolapse, the age of the patient, the desire for future pregnancies, the operative risk, and the presence of other significant pelvic findings. Although no definite standards have been established in this hospital, the vaginal hysterectomy has generally been reserved for women over thirty-five, or more commonly over forty, years of age. Only twelve of the cases here included were under thirty-five years of age. Three were in their late twenties and had, in addition to complete prolapse, such contra-indication for future pregnancy as pulmonary tuberculosis or grand multiparity. The other nine were multipara in their early thirties, two of them having had a previous suspension.

Pathologically, ninety-eight of the 144 uteri were normal, twenty-three had small intramural myomata of no pathological significance, fifteen had adenomyosis, while the remainder had various findings, such as endometrial hyperplasia, endometrial polyps, or endocervical polyps.

Pelvic Inflammatory Disease

Although pelvic inflammatory disease can sometimes be treated without surgery, the resultant pelvic adhesions, tubo-ovarian abscesses, and fibrosis only too frequently require operation. The condition is thus a generally accepted indication for hysterectomy with salpingo-oophorectomy.

Of the 104 cases included in this group, ninety-three had chronic salpingitis, seven had acute salpingitis, two had only perimetritis and peritubal adhesions, and two cases had extensive adhesions at operation which were not described on the pathological report. Of the uteri removed with the diseased tubes and ovaries, sixty-three were normal, fourteen had adenomyosis, and the other twenty-seven had various non-significant pathological lesions.

Clinically, the diagnosis was made in eighty-seven (84 per cent) of the cases. The other diagnoses were ovarian cyst, endometriosis, tubal pregnancy, adenomyosis, and acute appendicitis.

Endometriosis

The numerous methods of treating this condition cannot be evaluated here. Wherever bilateral oophorectomy was considered to be the treatment of choice for a case of endometriosis, the concomitant hysterectomy was considered indicated, since the patient was being subjected to an operative and anesthetic risk in any case, and the remaining uterus would be a useless, non-functioning organ.

Endometriosis is not only clinically, but often pathologically quite difficult to differentiate from pelvic inflammatory disease. If a diagnosis of endometriosis was made clinically, but only adhesions and fibrosis were found on pathological examination, the condition was included in the group of pelvic inflammatory diseases. There then remained a group of thirty-eight uteri of

which thirty-five had nests of ectopic endometrial tissue, either in the tubes, ovaries or on the uterine surface. Two others had adhesions and cysts containing evidence of old hemorrhage, but now lined by unrecognizable tissue compatible with endometrial epithelium. One patient had had a previous endometrial ovarian cyst removed and diagnosed pathologically, however, after hysterectomy only adhesions and fibrosis could be found.

Clinically twenty-eight cases were diagnosed correctly, an accuracy of 74 per cent. The remainder were variously diagnosed as pelvic inflammatory disease, myoma, and ovarian cysts.

Ovarian Tumors

This constitutes a group of thirty-eight cases in which the ovarian lesion made the associated removal of the uterus an indicated procedure. In all cases, the remaining uterus would have been a functionless organ. There were four groups of cases: 1. A unilateral ovarian neoplasm or non-neoplastic cyst in a patient with a previous oophorectomy; 2. a similar unilateral ovarian lesion occurring during the menopause; 3. a bilateral benign ovarian lesion; 4. a malignant ovarian neoplasm.

Pathologically, the lesions fell into several groups. If the tumor was a neoplasm, either solid or cystic, oophorectomy was, of course, warwanted. A bilateral oophorectomy was indicated if the neoplasm was considered at operation to be malignant. If the tumor was a non-neoplastic follicle or lutein cyst, oophorectomy was not considered indicated unless the cyst was at least 4 centimeters in diameter.

Of the uteri removed with these diseased ovaries, five had small intramural myomata, four had adenomyosis, and twenty-nine were normal.

Malignant Neoplasms of the Body of the Uterus

Since this is not a discussion of therapy, all hysterectomies for malignancy of the uterus were considered indicated. The group of thirty-three cases consisted of thirty-one adenocarcinomas, one sarcoma botryoides, and one chorion-epithelioma. Of the thirty-one adenocarcinomas, twenty were post-radiation, while six were treated by initial hysterectomy, following a diagnostic curettage.

Six of these cases were not diagnosed preoperatively. Five of these were adenocarcinomas, four removed for a clinical diagnosis of myomata and the fifth for a prolapsed uterus. The sixth, removed with a preoperative diagnosis of ectopic pregnancy, was a chorion-epithelioma which had eroded through the myometrium.

Malignant Neoplasms of the Cervix of the Uterus

Although radiation is considered the treatment of choice for invasive carcinoma of the cervix (stages 1 through 4), this is not necessarily true of pre-invasive carcinoma (carcinoma in situ, or stage 0). Of the thirty-three uteri removed for carcinoma of the cervix, five were not diagnosed before operation. Of the remaining 28, twenty had a preoperative diagnosis of pre-invasive carcinoma, and four more were removed post-radiation. The five undiagnosed cases consisted of three diagnosed as myomata, one as prolapse, and one as chronic cervicitis.

Chronic Dysfunctional Bleeding

The management of this condition is one of the most perplexing problems that confronts the gynecologist, and one of the most difficult to solve to the satisfaction of all concerned. Before considering hysterectomy as an acceptable treatment for this condition, several criteria should be satisfied.

First, the bleeding must be truly abnormal, either in amount or interval, and not just consist of such irregularities of menstruation as might be expected during the menopause. These facts were often quite difficult to appraise from a chart in which, for example, a patient with a hemoglobin of 95 per cent, complained of "menorrhagia."

Once having established an abnormality of bleeding, the patients could be divided into two

groups; those who bled at abnormal time intervals and those who bled abnormal amounts. In this latter group a curettage was considered necessary both as a diagnostic and therapeutic procedure. If bleeding ceased, the case obviously did not warrant hysterectomy. If it ceased, but subsequently recurred, a trial on endocrine therapy and a second curettage were considered desirable before hysterectomy. If the bleeding recurred a year or more after the first curettage, a second was considered mandatory to rule out either retained secundines or the presence of carcinoma.

In practice, these strict criteria were frequently relaxed. In a woman at the menopause, a minimum of one diagnostic curettage was required with a sufficient time interval between curettage and hysterectomy to constitute an adequate therapeutic trial.

A diagnostic curettage was considered mandatory in the group bleeding at abnormal time intervals, either in the form of metrorrhagia, or post-menopausally. Since these patients presented no surgical emergency from exsanguination, both medical measures and a curettage were considered even more strongly indicated as a therapeutic procedure preceding hysterectomy.

Pathologically, of the thirty uteri removed for dysfunctional bleeding, seven had intramural myomata of no pathological significance, two had hyperplasia of the endometrium, and twenty-one were completely normal.

Obstetrical Indications

Hysterectomy at the time of Cesarean section[3] and in the immediate puerperium[7] has increased in popularity in recent years. However, this procedure is primarily reserved for patients in their late thirties or early forties. Of the twenty-four hysterectomies performed on the obstetrical service, fifteen were done for sterilization. Three uteri were removed for rupture during labor, three were Couvelaire uteri, two had a clinical diagnosis of placenta accreta, and one uterus was inverted.

Miscellaneous

This inevitable group terminating any list or classification included twenty-five cases. Five had metaplastic conditions of the cervix variously labelled Bowen's disease, hyperkeratosis, or leukoplakia, and one showed adenomatous change of the endometrium. Four cases were removed for endometrial polyps. The others included such conditions as an ectopic pregnancy in the uterine cornu, castration for carcinoma of the breast after no more radiation could be given, accidental uterine perforation during curettage, and pelvic carcinoma with metastasis to the uterus or with a slightly enlarged uterus interfering with a Miles procedure.

Pathologically, nine of the uteri were normal.

Non-indicated Hysterectomies

All of the 123 cases included in this group were carefully analyzed by four independent observers, who agreed that the uteri were removed without either clinical or pathological justification. Clinically, these patients consisted of several groups.

The first group consisted of twenty-seven patients complaining of bleeding who were treated improperly. This was the largest group in which a uniform pattern could be discerned. Twelve of these had such complaints as irregularities of the menstrual period, scanty or slightly profuse flow, an occasional missed period, and similar irregularities of menstruation as might be expected with the menopause.

Fifteen additional patients had truly abnormal uterine bleeding. Of the seven who had a hysterectomy without any preceding curettage, three had retained secundines in the removed uterus. The remaining eight had a curettage a few days preoperatively and a hysterectomy was performed although the bleeding had stopped.

The next largest group consisted of fifteen patients with a clinical diagnosis of myomata. They had such vague, ill-defined complaints as pelvic pain, backache, and pressure in the pelvis. Pathologic examination revealed either no lesion,

or myomata of such small size that they could not meet the criteria for hysterectomy mentioned above. The largest single intramural myoma included in this group was 5 centimeters in diameter, the smallest 0.5 centimeters.

The remaining eighty-one cases had clinical diagnoses ranging throughout all possible gynecological lesions, none of which was found either at operation or pathological examination. The reasons for the removal of such uteri could never be comprehended by the authors, nor ascertained from the patients' charts.

Pathologically, of the 123 uteri removed, sixty-seven were completely normal, and forty-six had intramural myomata of no pathological significance. The remaining ten included one pregnant uterus misdiagnosed as a myoma, three incomplete abortions, one bifid uterus, one diagnosed as adenomyosis, one cervical polyp, one parauterine hematoma, and two diagnosed as passive congestion.

DISCUSSION

Several interesting facts emerge from this analysis. In this series, as in other reports,[4, 5] myomata are the most common indication for hysterectomy. The other indications show few differences from those in the literature or in standard texts. However, the incidence of what is considered to be a "non-indicated hysterectomy" as the fourth highest deserves further discussion.

It should be emphasized once again, that it is not the removal of a normal uterus, but also the removal of a uterus showing lesions of no pathological significance that must be considered in this group. If the discussion is limited to normal uteri only, Table 2 shows that 287 of the 1000 fall into this group. Of these 287, seventy-six per cent (or twenty-two per cent of the 1000) are removed for a valid indication. Sixty-seven of the normal uteri were removed without justification, constituting 23 per cent of the normal uteri or 6.7 per cent of the 1000, a figure which compares quite favorably with Bieren's[2] 14 and 2.5 per cent.

TABLE 2

Indications for the Removal of a Normal Uterus

Indication	Number	Per Cent
Prolapse	98	34
Pelvic Inflammatory Disease	63	22
Ovarian Tumors	29	10
Dysfunctional Bleeding	21	7
Miscellaneous	9	3
Not Indicated	67	23
Total	287	

Returning then to an analysis of the hysterectomies considered non-indicated, several factors emerge. As already discussed, greater technical facility with better training, control of infection, and improved post-operative care probably accelerates many a decision to perform hysterectomy. These factors are reflected in the increasing number of hysterectomies for prolapse (Table 3).

However, other factors have operated during these seven years, and are reflected in some alterations of the statistics. Although most of the valid indications for hysterectomy have remained relatively stable throughout this period (Table 3), there was a sharp decline in the incidence of the "non-indicated hysterectomies" in 1953, and a still larger decrease for 1954. This is graphically illustrated in Table 4. A strong correlation is believed to exist between this decline and the formation of a tissue committee in October, 1952. A second fact also emerges from Table 4. The year 1952 showed an exceptionally high incidence of "non-indicated hysterectomies" over previous years. Further analysis of the twenty-three cases for 1952 revealed that four such non-indicated procedures were performed by a single surgeon. This performance has not been repeated. Corrected for these four cases, the incidence for that year then falls in line with the other years.

Also worthy of note is the high incidence of the mistaken diagnosis of myoma. Many of the uteri removed for this diagnosis showed infinitesimal myomatous neoplasms. Its frequent finding at autopsy probably tends to lead the surgeon too often to this diagnosis. In addition to the fifteen hysterectomies mistakenly performed for myomata, the diagnosis was also made erroneously

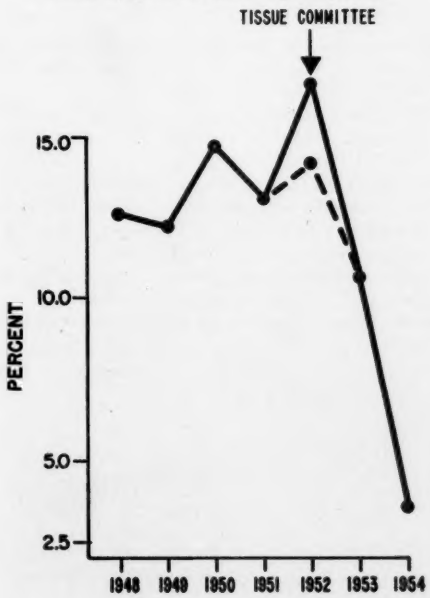
TABLE 3

Annual Variation in Incidence of Indications for Hysterectomy

Indication		1948	1949	1950	1951	1952	1953	1954	1955	Total No.
Myoma	No.	45	34	37	53	31	33	25	2	260
	%	31.5	24.5	23.7	31.5	22.5	25.0	22.1		
Adenomyosis	No.	27	36	23	14	19	18	9	2	148
	%	18.2	26.1	14.7	8.3	13.8	13.6	8.0		
Prolapse	No.	4	12	29	29	24	21	21	4	144
	%	2.8	8.7	18.6	17.3	17.4	15.5	18.6		
Pelvic Inflammatory Disease	No.	24	19	12	18	6	8	17		104
	%	16.8	13.8	7.7	10.7	4.3	6.1	15.0		
Endometriosis	No.	3	1	5	6	10	7	5	1	38
	%	2.1	0.7	3.2	3.6	7.3	5.3	4.4		
Ovarian Tumors	No.	10	5	7	4	4	6	2		38
	%	7.1	3.6	4.5	2.4	2.9	4.5	1.8		
Malignancy—Corpus Uteri	No.	6	4	3	5	2	8	5		33
	%	4.2	2.9	1.9	3.0	1.4	6.1	4.4		
Malignancy—Cervix Uteri	No.	0	1	10	7	2	4	8	1	33
	%	0	0.7	6.4	4.2	1.4	3.0	7.1		
Dysfunctional Bleeding	No.	1	5	3	6	3	4	8		30
	%	0.7	3.6	1.9	3.6	2.2	3.0	7.1		
Obstetrical Indications	No.	4	2	1	1	4	6	6		24
	%	2.8	1.4	0.6	0.6	2.9	4.5	5.3		
Miscellaneous	No.	1	2	3	3	10	3	3		25
	%	0.7	1.4	1.9	1.8	7.3	2.3	2.7		
Not Indicated	No.	18	17	23	22	23	14	4	2	123
	%	12.6	12.3	14.7	13.1	16.7	10.6	3.5		
Total		143	138	156	168	138	132	113	12	1000

TABLE 4

Incidence of Non-indicated Hysterectomies



numerous times when, on further analysis, some other indication for the hysterectomy was found. Thus it was made in 45 per cent of the hysterectomies for adenomyosis, 10.5 per cent of those for endometriosis, four of the undiagnosed carcinomas of the body of the uterus, and three of the undiagnosed carcinomas of the cervix. It might be worthwhile to emphasize again that the presence of a myoma is not an indication for hysterectomy unless it is submucous, or of such a large size, either single or collectively, as to distort the uterus and to rise out of the pelvis, or shows sudden growth.

In the older age group, a common mistake appears to be the misinterpretation of menopausal symptoms. These irregularities, normal at that period, are designated as menometrorrhagia and hence considered abnormal. Here again, conservative measures, and enlightenment of the patient will probably obviate an unnecessary hysterectomy many times.

Conversely, a diagnostic curettage for any bleeding in any age group is an absolute necessity, and the removal of a uterus for bleeding without a diagnostic curettage is inexcusable. Six undiagnosed cases of uterine malignancy, three retained secundines, and one misdiagnosed viable pregnancy amply attest to this fact.

Similar arguments pertain to the routine cervical biopsy preceding a hysterectomy, especially if there is any type of cervical lesion. Five undiagnosed carcinomas of the cervix found at pathological examination prove the necessity of this procedure.

CONCLUSION

An analysis of 1000 hysterectomies leads to several conclusions.

1. The "non-indicated hysterectomy" was the fourth most common type of hysterectomy performed, with an incidence of 12.3 per cent.
2. Several consistent mistakes contributed to this high incidence.
   a. Failure to recognize and evaluate the symptoms of the menopause.
   b. Frequent misinterpretation of the significance of small myomata by attributing to them such vague symptoms as low back pain and abdominal discomfort.
   c. Failure to do a diagnostic cervical biopsy and uterine curettage.
   d. Failure to test the therapeutic efficacy of a curettage in the control of uterine bleeding.
3. Several measures are suggested to control this situation.
   a. As far as possible, a broad, generally acceptable standard of indications for hysterectomy might be desirable for the open staff hospital.
   b. Consultations should be encouraged and recommended in equivocal cases.
   c. A careful written record of history or physical findings might many times contain data, at present inaccessibly stored in someone's memory, which makes a "non-indicated hysterectomy" an indicated one.
   d. It is becoming increasingly evident, and is attested by the striking decrease in the incidence of the "non-indicated hysterectomy" after 1952, that a tissue committee composed of responsible department heads with adequate authority is a desirable integral part of any well functioning hospital.

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CAT SCRATCH DISEASE MANIFESTED BY GENERALIZED LYMPHADENOPATHY

Case Report

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Well over three hundred cases of Cat Scratch Disease have been reported from the U.S.A. and many foreign countries in Europe and South America. A recent review of 160 cases of the disease by Dr. Worth B. Daniels summarizes the accumulated experience with this disease.[1] It is characterized mainly by an indolent primary lesion and regional lymphadenopathy. There are usually constitutional symptoms to a greater or lesser extent, and often suppuration of lymph nodes. The result of antibiotic therapy certainly does not approximate the result obtained in various other acute infections; although their use seems to prevent suppuration of the glands.[2] Cortisone seemed to bring about dramatic improvement in the primary lesion and lymphadenitis in a case of Cat Scratch Disease associated with thrombocytopenic purpura.[3]

Some unusual manifestations of Cat Scratch Disease are Parinaud's syndrome, encephalitis, erythema multiforme, erythema nodosum, abdominal pain, osteolytic bone lesions, and thrombocytopenic purpura. Some of the diseases with which Cat Scratch Fever may be confused are lymphomas, pyogenic adenopathy, tuberculous adenitis, tularemia, lymphogranuloma, and infectious mononucleosis.

In the literature reviewed generalized lymphadenopathy has not been mentioned. This is somewhat surprising in view of the fact that the disease always affects regional glands, plus many other organ systems. The development of generalized lymphadenopathy could, therefore, be cause for grave concern as to the nature of the illness. Fortunately, in the case being reported a strongly positive skin test plus rapid subsidence of the adenopathy cleared the issue.

* We are indebted to Dr. Ivan Bennett for his advice and for the Cat Scratch Antigen.

CASE REPORT

The patient N. K. L. was first seen on December 17, 1954 with a history of a tender, inflamed, papule of about two to three weeks duration on the volar surface of the left arm near the wrist. She did not remember the exact mode of onset of this papule. There had been no contact with cats. On December 14, she had noticed a tender, enlarged lymph node on the inner side of the left arm plus several tender axillary lymph nodes. She did not feel ill and had had no chills or fever. Her past history was non-contributory.

Physical examination revealed a very thin white female who did not appear acutely or chronically ill. Her temperature was 98.0 degrees and her blood pressure was 100/70 mm Hg. There was a dime sized, red, slightly tender papule on the volar surface of the left arm near the wrist. There was a tender, bean sized gland midway between the elbow and axilla; and also several enlarged tender glands in the left axilla. It was our first impression that the patient had a pyogenic adenitis. The patient was put on procaine penicillin. Over the next five days her condition grew steadily worse. The large gland on the inner surface of the left upper arm became much larger and much more tender; with marked erythema in the overlying skin. The axillary glands also became larger, coalescent, and exquisitely tender. A firm tender cord appeared between the cubital fossa and the axilla. The temperature during this time was never over 99.6 degrees. There were no constitutional symptoms except for persistent headache. The appetite remained good.

On December 22, the patient developed generalized urticaria. Penicillin was discontinued and Erythromycin started. On December 24, Achromycin was begun. By this time, because of the worsening of symptoms and because of a vague history of rabbit contact, we began to consider Tularemia. Cat Scratch was also thought of for the first time at this point. Agglutination for Tularemia proved to be negative.

On December 29, the patient was admitted to Lutheran Hospital for further study. At this time her

physical examination was substantially as reported above.

LABORATORY RESULTS

Hemogram was normal except for an initial W.B.C. of 10,400, with a normal differential. Sedimentation rate was 38 and 31. Fasting blood sugar 77 mg. per cent, urea 27.8 mg. per cent; total protein 5.8 gm. per cent; serum albumin 4.0 gm. per cent; serum globulin 1.8 gm. per cent. Urinalysis was normal. Three blood cultures for ordinary pathogens and for B. Tularense were negative. Cultures of the primary ulcer for Tuberculosis, ordinary pathogens, and B. Tularense were negative. Stool cultures were negative. Blood agglutinations for Tularemia were negative. Heterophil antibody test on January 7 and January 24 was 2 plus at 1:28 and 1 plus at 1:112. This was not considered significant. Intradermal test with Cat Scratch antigen produced a red, indurated area measuring 1.2 by 2 cm.

COURSE IN HOSPITAL

For a period of about two days after entry into the hospital, there was a temporary decrease in the size and tenderness of the enlarged glands; then the patient's condition again worsened. On January 1, 1955, a gland appeared under the axillary border of the left pectoral muscle, and just beneath the clavicle. On January 22, a large gland appeared between the origins of the left sternomastoid muscle; and small glands began to appear in the neck bilaterally, in the right axilla, and in both inguinal regions. The glands under the pectoral muscle plus one gland in the left inguinal region were tender. On January 1, the papule on the forearm ulcerated. The tender cord between the gland on the inner side of the arm and the axilla became softer and less tender; but the cord between the above gland and the cubital fossa became worse. There was no fever after January 1, 1955.

The patient was discharged from the hospital on Achromycin on January 7, following which she showed rapid improvement. The enlarged glands in all areas became smaller, and the tender cord on the inner side of the arm became softer and less tender. Achromycin was discontinued on January 18. When seen on February 4, the gland and tender cord on the inner side of the arm were gone. A few small non-tender, discrete glands remained in the left axilla, and one small gland could be felt in the right axilla. The last visit on March 25 revealed only a few, small, non-tender glands in the left axilla. The ulcerated papule had completely healed without scarring, leaving only a round pigmented area.

SUMMARY AND CONCLUSIONS

A case of Cat Scratch Disease is reported manifested by hitherto unreported generalized lymphadenopathy. The typical clinical manifestations plus positive skin reaction to the antigen leave little doubt as to the diagnosis. The presence of generalized lymphadenopathy, therefore, need not deter one from making the diagnosis of Cat Scratch Disease.

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OUR EXPERIENCE WITH VALLESTRIL IN THE PUERPERIUM

ANTONIO Q. PARAISO, M.D., and LEON GREENWALD, M.D.*

Many articles have been written concerning the beneficial use of estrogens and/or androgens in the depression or inhibition of lactation, and relief of breast pain and breast engorgement in the early postpartum period. Clinical usage

* We wish to thank the members of the visiting staff for allowing use of their clinical cases and the nursing staff of the obstetrical department of the Lutheran Hospital for their help in collecting the data. We are grateful to the Searle Company for supplying us with Vallestril tablets, thereby helping to make the experiment possible.

among obstetricians varies widely from rejection to routine employment. Stilbesterol and testosterone have been the agents most commonly tested. Reports have borne out the fact that an ideal drug has yet to be found because of some undesirable reactions noted during their administration (most frequently nausea), upon withdrawal of the drug (resumption or return of milk secretion and vaginal bleeding), and upon prolonged administration (carcinogenic effect for estrogens and potential masculinizing effects for androgens).

Quite a few papers, however, have recently been published regarding new estrogenic products, namely (chlorotrianisene) (Tace—Wm. S. Merrell Co.) and (methallenestril) (Vallestril—G. D. Searle and Co.). Whether or not these two new estrogens are better than the older estrogens still remains to be proven by more lengthy experience in their usage. This present series deals with our experience with Vallestril, mainly for the relief of breast pain and breast engorgement. The role that Vallestril plays in the suppression of lactation was not consistently sought in this series, because return of milk secretion in about 50% of the first 100 unselected clinical cases, invariably occurred after discontinuation of the drug and follow-up of the rest of the cases concerning this effect seemed rather discouraging. We thereby decided that the term "suppression of the lactation" was an incorrect designation of the Vallestril effect, inasmuch as the effect lasted only during administration of the drug and even failed to do so in some cases.

In our Obstetrical Department, from April 19 to August 23, 1953, we administered Vallestril tablets to 203 patients, 161 patients serving as controls. Three of the control patients and two of the experimental patients had no telephone numbers and thus could not be contacted; one control patient was erroneously given 25 mgs. of Testosterone by intramuscular route during her second postpartum day. These six cases are therefore excluded from this series. Each of the 203 experimental cases received a daily dose of 18 mgs. (two 3-mg. tablets t.i.d.), or a total dosage of 180 mgs. for the whole course of ten days. Medication was started within twenty-four hours after delivery. All the experimental as well as the control patients received other treatment in the form of breast binders or brassieres, ice bags, and Aspirin (gr. X)—Codeine (gr. I) whenever necessary. There was no restriction of fluids. Follow-up was accomplished while the patient was still in the hospital (invariably 3–5 days postpartum for those that had uncomplicated vaginal deliveries and a week or longer for operative cases) and upon completing the whole course of the drug, by telephone and by actual interview or by telephone.

RESULTS

From Tables 1 and 2, we can see that there is great disparity between the data obtained from experimental patients and from control patients in the matter of breast pain; ninety-one per cent vs. fifty-seven per cent for patients without breast pain and nine per cent vs. forty-three per cent for patients with breast pain. Likewise, there is a disparity between the data for both types of patients regarding breast engorgement; seventy-one per cent vs. twenty-four per cent for patients without engorgement and twenty-nine per cent vs. seventy-six per cent for patients with engorgement. It may also be mentioned at this point, that patients complaining of breast

TABLE 1

Relief of Breast Pain with Vallestril

	With Pain	Without Pain
Experimental cases (56%)	18 (9%)	185 (91%)
Control cases (44%)	69 (43%)	92 (57%)

TABLE 2

Relief of Breast Engorgement with Vallestril

	With Engorgement	Without Engorgement
Experimental cases	58 (29%)	145 (71%)
Control cases	122 (76%)	39 (24%)

pain do not necessarily exhibit breast engorgement and vice versa. Then, too, there is no correlation between age, parity, and the occurrence of breast pain and breast engorgement, as was gathered in the course of arriving at the data in the two preceding tables already presented; neither is there a correlation existing between the type of patient (private or service) and the likelihood of having breast pain and breast engorgement.

Regarding the side reactions emanating from the oral intake of Vallestril, no authentic data could be obtained, owing to the fact that such side reactions (nausea, vomiting, urticaria, headache, etc.) could have been brought about by the anesthesia used during the delivery (namely, saddle block, pudendal block or balanced mixture), and prophylactic antibiotics used especially for premature and prolonged rupture of membranes. Nevertheless, during follow-up by telephone or by personal interview, there was not a single patient that ever complained of any of the aforementioned side reactions, attributable to taking in the rest of the Vallestril course at home. There was no complaint of a patient's having exhibited any withdrawal bleeding. One patient in the experimental series who had undergone a Caesarean hysterectomy, experienced vaginal bleeding two weeks postpartum but this subsided without treatment and the patient was subsequently seen on her sixth week check-up in very good condition.

OUR EXPERIENCE WITH VALLESTRIL IN THE PUERPERIUM

Summary

1. Relief of breast pain in ninety-one per cent of 203 clinical cases was brought about by the administration of Vallestril (given two 3-mg. tablets t.i.d. for ten days), medication being promptly started within twenty-four hours after delivery.

2. Relief of breast engorgement in seventy-one per cent of 203 cases was brought about by the administration of the same drug with identical dosage and manner of administration.

3. No side reactions were observed.

4. Vallestril is a useful drug in relieving breast pain and breast engorgement in the early puerperium.

5. This drug is one of the cheapest of the estrogenic preparations.

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HYPAQUE: A NEW DRUG FOR EXCRETORY UROGRAPHY

A Preliminary Clinical Report

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A number of drugs have been produced in the pharmacologic laboratories for excretory urography since the report by Swick (1) in 1929. All of these have been valuable in the delineation of the upper urinary tracts in the radiograph, making visible the calyceal systems, the kidney pelvis, the ureters, and the bladder. Information is also obtained regarding the functional activity of these organs. However, all these drugs have been associated with some measure of allergic and vasomotor side reactions ranging from mild discomfort to unconsciousness. Some drugs have caused the rare misfortune of the death of the patient.

The preparation of a urographic drug which produces a clear anatomic outline of the urinary tracts in a radiograph and which does not produce an untoward reaction in the patient is an achievement greatly to be desired. No such drug has yet been made available. However, a new drug, Hypaque (sodium 3,5-diacetamido-2,4,6-triiodobenzoate), has been released which represents a welcome step in this direction. The excretory urograms made after injection of this drug give good visualization of the kidneys, ureters, and bladder with a lesser incidence of ill effects in the patient.

This report is concerned with fifty patients, selected at random, who were injected with 30 cc. of a 50% solution of Hypaque. At the same time another drug in new concentration, a 50% solution of Urokon sodium (sodium 3-acetylamino-2,4,6-triiodobenzoate), was injected into fifty other patients also selected at random. The patients were carefully questioned about previous reaction to any injection and about allergic history or background. A test intravenous injection of 1 or 2 cc. was given and if no reaction occurred within two minutes, the rest of the medium was injected slowly. Radiographs were made at 5, 10 and 15 minutes after the end of the injection. These were read and graded as to quality of delineation of the urinary tracts.

Chart I demonstrates the record for each

CHART I

Intravenous Urography

Name
X-ray number
Date and time of day
1. Have you ever had this type of examination before?
2. If so, did you have a reaction?
3. Have you ever had hay fever, hives, asthma, eczema?
4. Have you ever had a reaction to any injection?
History of allergy

Reactions observed in x-ray department
1. Feeling of warmth
2. Arm pain
3. Nausea
4. Vomiting
5. Urticaria
6. Laryngeal edema (asthma, wheezing)
7. Unconsciousness
Delayed reaction
Nature
Quality of examination
Excellent
Fair
Unsatisfactory
A. Preparation
B. Density of dye
Preparation: None Fair Good
Urea
Specific gravity
Sensitivity test
Drugs for reactions

* From the Department of Roentgenology.

Hypaque was kindly supplied by Winthrop-Stearns, Inc. Urokon 50% was in part supplied by Mallinckrodt Chemical Works.

patient, following the method used by Robbins et al. (2). Reactions 1 and 2 were graded as mild; reactions 3, 4 and 5 as moderate; and reactions 6 and 7 as severe. The quality of the films was characterized as excellent when all the calyces, the kidney pelves, and the ureters were outlined in one or more films. The bladder was usually outlined but not considered of equal importance. The films were graded fair when the calyces, kidney pelves, and ureters were partially outlined in the combined films. The term unsatisfactory is self-explanatory, due to poor preparation of the patient or insufficient density of the excreted drug.

Chart II records the findings in these cases. The number of patients with one or more side reactions is higher for Urokon 50% than in previous reports (2, 3). This may be due to the higher concentration of this drug or due to recording of even minor symptoms of the types listed. However, this latter factor would apply for both drugs used. It is worthy of note that no serious reactions occurred in these one hundred patients. The percentage of patients with one or more reactions was 22% for Hypaque and 56% for Urokon 50%. Hypaque also was found to give a higher percentage of excellent urograms. Although there were more unsatisfactory examinations with Hypaque, all of these patients had elevated ureas and impaired renal function.

CHART II

	Hypaque		Urokon 50%	
	Number	Per Cent	Number	Per Cent
Reactions				
Patients with one or more reactions	11	22	28	56
Mild reactions	4	8	17	34
Moderate reactions	8	16	19	38
Severe reactions	0	0	0	0
Quality of Films				
Excellent	30	60	25	50
Fair	17	34	24	48
Unsatisfactory	3	6	1	2

CONCLUSIONS

1. A preliminary report is submitted on the qualities of sodium 3,5-diacetamido-2,4,6-triiodobenzoate (Hypaque) as an intravenous urographic drug. The side reactions as well as the delineation of the urinary tracts in 50 patients have been recorded.

2. These qualities have been compared with sodium 3-acetylamino-2,4,6-triiodobenzoate (Urokon sodium 50%).

3. Fewer reactions and better visualization of the upper urinary tracts were noted with the use of Hypaque sodium 50% solution.

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HYPOGAMMAGLOBULINEMIA*

Report of Case and Review of Literature

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Alterations of serum proteins in various diseases have been thoroughly investigated and reviewed.[1, 2] Introduction of electrophoretic studies made possible a greater understanding of chemistry and physical properties of proteins. Actually, the migration of proteins in an electric field was discovered by W. B. Hardy in 1899 but the modern technique of electrophoresis was largely developed by A. Tiselius in early 1935. In the past ten to fifteen years, more attention has been paid to the significance of electrophoretic patterns in various disease processes[3, 4, 5, 6] with emphasis on the serum gamma globulin fraction.[7, 8, 9, 10, 41, 44, 49, 67]

Agammaglobulinemia was first reported by O. C. Bruton in 1952.[11] Since that time, many reports have appeared in the literature[12-39] along with studies of immunological aspects. Owing to the simplicity of paper electrophoresis, which was first introduced in 1950 by three different groups of people, Durrum[58] in America, Cremer and Tiselius[57] in Sweden and Turba and Enenkel[46] in Germany, extensive surveys of patients of various types of alteration of protein pattern was made possible. Altogether, not less than 50 cases of agammaglobulinemia or hypogammaglobulinemia were reported in a short period of three years. Most of the studies were confirmed by other methods, such as classical Tiselius electrophoresis, salt precipitation and immunochemical analyses.

A seven year old girl was admitted to the Lutheran Hospital of Maryland eight times from 1951 to 1954. She had a variety of infections including recurrent otitis media, pneumonia, bronchiectasis and generalized furunculosis. The diagnosis of hypogammaglobulinemia was finally made by paper electrophoresis.

CASE REPORT

D. H. (R-6738), a five year old white girl, was first seen at the Lutheran Hospital Out-patient Department, Pediatric Clinic on October 12, 1951 because of a bilateral purulent otitis media with perforation on the right side and an impetiginous pyoderma involving the face, hands, legs and arms. A large dose of penicillin was given, along with prescriptions for continued therapy at home and an appointment made for follow-up in the E.N.T. Clinic. However, she was not returned to the clinic until two months later, at which time she was found to have impetigo over the trunk, face and all extremities, generalized lymphadenopathy, otitis media, right nasopharyngitis and a low grade fever. In view of a history of having improved on the previous therapy, she again was started on penicillin therapy and instructed to return in one week. On December 21, 1951 she was seen by the E.N.T. consultant, who felt that her recurrent upper respiratory infection must stem from a chronic residual infection in the sinuses.

At this time it was decided to admit her to the hospital for study and treatment. The complaints included cough, fever, nasal discharge, painful right ear and generalized skin eruptions. Other than an alleged bout of pneumonia at the age of 3, and chickenpox at the age of 18 months, her past childhood history was negative. Both parents and 3 siblings were said to be well. A review of systems was negative except for the recent multiple infections during the preceding months as noted in the clinic record. Physical examination revealed a well developed, well nourished, alert and cooperative young child, obviously febrile (104.8 R) whose skin was erupted with crusted

* We should like to acknowledge our indebtedness to Dr. Julius Waghelstein of Baltimore, who on the occasion of his visit to this patient in consultation first made the suggestion of the possibility of agammaglobulinemia, and upon his recommendation, the electrophoretic studies which established this diagnosis, were made. We are also indebted to Dr. Frederick W. Barnes, Jr., Associate Professor of Medicine, Johns Hopkins University School of Medicine for valuable assistance with this paper.

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and vesiculated lesions. The tonsils were enlarged, follicular and inflamed. The nasal passages were obstructed by congestion. Cervical glands were enlarged, neck supple. The breath sounds were impaired at the left base with dullness to percussion in the same area. The remainder of the physical examination was within normal limits. On the day of admission the hemoglobin was 11.8 gm.; white cell count 19,200 with 79 per cent neutrophils; 18 per cent lymphocytes and 3 per cent monocytes. Subsequent white counts dropped to 11,650 with no significant change in the differential. Although urine cultures were negative, repeated specimens microscopically showed pus cells ranging from 10 cells/Hpf up to clumps too numerous to count. The corrected sedimentation rate was 45, blood urea 36.3 mg. and blood sugar 70 mg. Culture of the right ear revealed a hemolytic staph. albus, of the nose and throat alpha strep hemolytic staph. albus, hemolytic staph aureus, coagulase positive. X-ray of the paranasal sinuses confirmed the impression of a bilateral maxillary and ethmoidal sinusitis. The mastoid regions were found to be well developed and without abnormality. Chest X-rays on admission revealed a pneumonia in the right base and repeated films on December 21 showed pneumonitis in both bases with no evidence of resolution. She was treated with penicillin 100,000 q. 4. h. for 2 days and then q. 6. h. thereafter and kept at bed-rest. Her course was one of progressive and rapid improvement, becoming afebrile and asymptomatic by the third hospital day. The skin infection was treated locally with improvement and she was discharged on the 11th hospital day, asymptomatic, and without any physical signs other than the healing impetigo, although on X-ray the inflammatory changes had not cleared. The summary diagnoses made at the conclusion of this hospitalization were otitis media, bilateral, acute, purulent, with perforation on left, due to hemolytic staph. albus; follicular tonsillitis and nasopharyngitis, due to mixed bacterial infection; bilateral pneumonitis; bilateral maxillary and ethmoidal sinusitis; adenoiditis; and impetigo contagiosa. She was discharged without antibiotics, to be followed in the Out-patient clinic.

On January 21, 1952 she was readmitted for the purpose of bronchoscopy and to have a tonsillectomy and adenoidectomy. Routine blood counts and smears and urinalyses were essentially negative. X-rays of the chest showed a decrease in the mottled densities seen in both bases on previous admission. Bronchoscopy was done, revealing a thick, purulent exudate coming from both bases. Studies for malignant cells and acid-fast organisms were negative. The reports on the bacterial cultures were lost. An uneventful tonsillectomy and adenoidectomy was done and she was discharged with tentative plans for a bronchogram to be done in the future.

Again she was not returned to the clinic for follow-up care until March 19, 1952 when she was brought to the clinic with pneumonitis in both bases. Two days after admission she broke out with an obvious rubeola rash and was at once transferred to the Infectious Diseases Unit of the Baltimore City Hospitals where she was treated throughout the course of her 7 day hospitalization there with Aureomycin 200 mg. q. 8 h. She improved clinically, and on X-ray showed marked clearing of the infiltration at both bases. This clearing, however, was not complete and she was readmitted to Lutheran Hospital for bronchography. Routine blood counts and urinalyses were within normal limits. Physical findings included dullness at both bases, mostly on the right, with bilateral basilar, fine, crepitant rales. The throat and tympanic membranes were slightly inflamed. For the first time, the tip of the spleen was noted to be palpable and on X-ray the splenic shadow was found to be enlarged. Bronchography revealed changes compatible with cylindrical bronchiectasis in the middle lobe and posterior segment of the right lower lobe bronchi. She was treated with postural drainage, bed rest and Aureomycin 200 mg. q.8.h. Over a 12 day course of treatment she improved clinically and X-rays of the chest showed for the first time complete clearing. She was discharged on a daily maintenance dose of Aureomycin 100 mg. q.i.d.

During the first month she remained symptom free, and on frequent physical examinations in the outpatient clinic, the chest was found to be clear. The dose of Aureomycin was reduced to 150 mg. b.i.d. She was seen monthly in the clinic until October 1952, during which time, with the exception of an occasional mild cold, she remained asymptomatic. By error, the Aureomycin was discontinued on September 3, 1952.

On October 12, 1952 she was readmitted to the hospital and a diagnosis of pneumonia involving almost the entire right lung and bilateral otitis media was made. A generalized lymphadenopathy and hepatosplenomegaly were noted but agglutination studies, smears and cultures were negative for infectious mononucleosis, typhoid, paratyphoid, brucellosis and the rickettsial diseases. Routine blood counts and urinalyses remained within normal limits. She was treated with penicillin, to which she responded quite dramatically, becoming afebrile in less than 30 hours and remaining so with a progressive remission of symptoms and nearly complete clearing of the chest on X-ray. She was discharged on a maintenance dose of Aureomycin 100 mg. t.i.d. She was seen in the clinic monthly and remained asymptomatic until March 1953.

On March 21, 1953 she was admitted because of a generalized furunculosis from which was cultured a mixed

growth of alpha strep. and hemolytic staph. aureus. Bronchoscopy done on this admission revealed a subacute inflammatory process. The scantiness of bronchial secretions was thought to be due to the fact that the patient had been on antibiotics and the findings were considered by the operator to be presumptive evidence of bronchiectasis in the right lower lobe. Cultures taken from this region grew alpha strep. and proteus, and were negative for acid-fast organisms. On bronchography, cylindrical changes were found in the middle segment of the right lower lobe, and suspicious changes in the lateral segment of the right middle lobe, the other regions appearing normal. Surgical consultants felt that the findings both on bronchoscopy and bronchography were not definite enough nor sufficiently localized to indicate surgical treatment. Again she was discharged on a maintenance dose of Aureomycin to be followed in the out-patient clinic.

Because it was noted that for more than one year the patient had not gained more than one pound of body weight, a repeat work-up was decided upon in September 1953. Bronchoscopy at that time revealed slight thickening and reddening of the bronchial mucosa but no evidence of bronchiectasis. On bronchography some cylindrical dilatation was reported in the left lower lobe bronchus with no abnormality on the right. Surgical consultants again felt that the changes were not consistent with a definite diagnosis of bronchiectasis and that they were not sufficiently localized to justify a surgical approach to the problem. Again she was followed in the out-patient department, and kept on prophylactic Aureomycin.

On March 21, 1954 this patient was again readmitted because of high fever, bilateral pneumonitis and generalized lymphadenopathy of a degree that was more marked than that seen in this patient previously. Repeated blood counts and differential smears were within normal limits with the exception of an initial white cell count of 16,000 (which subsequently fell to normal) with relative eosinophilia. Urea, blood sugar, Van Den Berg, thymol turbidity, cephalin flocculation, alkaline phosphatase, total protein and albumin-globulin ratio determinations were all found to be well within normal limits. Repeated urinalyses were likewise negative. Bromsulfalein retention test showed no retention after 45 minutes. Repeated L.E. cell preparations were negative. Gastric washings revealed no acid-fast organisms by smear, culture or guinea pig inoculation. First and second strength PPD tuberculin intradermal tests were negative. Duodenal drainage collected on two different occasions showed trypsin activity within normal limits. Various agglutination tests and antistreptolysin determination again showed negative results. X-rays of the chest showed conglomerate densities in the lower third of both lungs, mostly in the bases, with a widening of the right superior mediastinum. On fluoroscopy this widening was thought to represent peritracheal nodes. Repeated blood cultures were negative. Ps. Aeruginosa, Proteus, alpha strep., beta strep. and N. catarrhalis grew in the throat cultures. Excisional biopsy of several large lymph nodes from the right axilla was done and microscopic examination showed a reactive hyperplasia, compatible with inflammatory activity of a chronic infectious type. Specimens of serum were sent to laboratories at Johns Hopkins Hospital and at Sinai Hospital for electrophoretic determinations of globulin content. Both laboratories reported that no measurable quantity of gamma globulin was present in the serum. She was again discharged and maintained on 250 mg. of Achromycin. She was seen regularly each month and was found to have frequent bouts of lower respiratory symptoms characterized by fever, cough and anorexia. Complete bed rest seemed to aid in the recovery from these relapses. Now at the age of 8 years she weighed 40 pounds, the same as she had weighed two years previously. Special diets and vitamin supplement had no apparent effect upon her appetite and weight.

She was again readmitted to Lutheran Hospital because of the sudden appearance of a very large lymph node in the inguinal region, along with more enlargement of the spleen. Another lymph node biopsy was done and interpreted as hyperplasia. The plasma cell count was not elevated as would be suspected in the normal response to bacterial infections. Chest X-rays showed bilateral pneumonitis. Electrophoretic studies were repeated with the result showing the pattern of agammaglobulinemia or hypogammaglobulinemia.

The patient is still receiving antibiotics in maintenance doses, and is being followed on an out-patient basis. Since January 1955, she has been receiving 20 cc. of gamma globulin intramuscularly every six weeks. At the time of this writing she has remained asymptomatic and clinically free of any signs of active infection, although it is freely admitted that too little time has elapsed since the institution of this treatment to permit any reliable evaluation of results.

This is presented as a case of agammaglobulinemia with secondary pyogenic, multiple infections involving the upper and lower respiratory systems, ears and skin with possible bronchiectasis.

DISCUSSION

Since the first report of agammaglobulinemia by Bruton in 1952, many reports of this condition have appeared in the medical literature both in

this country and in Europe. The incidence of agammaglobulinemia is not known since appropriate methods for survey of large numbers of people have been available for only a short time. According to Verschure's[6] survey in 2300 patients, fifteen cases were discovered by paper electrophoresis with an absolute as well as a relative lowering of the gamma globulin content of the serum. Emmrich[26] also studied 700 cases of which six were found to have low gamma globulin in the serum. It is difficult to ascertain the incidence of this syndrome from these reports. We may also wish to differentiate a primary absence from lack secondary to nephrosis, malnutrition, neoplastic diseases, such as multiple myeloma, sarcoidosis, leukemia, a few cases of metastatic carcinoma, fulminating infections, eclampsia, Cushing's syndrome and many physiological conditions such as early infancy or pregnancy.

We do not know whether agammaglobulinemia is a new disease entity or whether it existed before the antibiotic era. According to C. A. Janeway's hypothesis,[12, 13] patients with agammaglobulinemia have low resistance and extreme susceptibility to bacterial infections. He believes that before introduction of antibiotics and chemotherapeutic agents, they may have died in early childhood.

A review of the literature of case reports of congenital hypoproteinemia indicated that this malady is somewhat different than the agammaglobulinemia described by Bruton.[42] From the earliest reports,[11, 12, 13] all of these patients were male. Janeway and Bruton, as well as Young and Wolfson,[19, 20] therefore, considered this disease to be the result of inborn defect due to recessive sex linked genes in homozygous males. From present available references we do find at least seven or eight cases reported in females. Roger Jean[14] reported a case of a seven year old girl with repeated pulmonary infections, mild leukocytosis, absence of gamma globulin and good response to administration of gamma globulin and antibiotics. Grant's case[28] was also a girl of 17 with repeated pneumonia, skin infections, dramatic response to antibiotics, absence of gamma globulin in the blood and failure to respond to antigenic stimulants. Sanford[27] also reported a 39 year old housewife suffering from this disease. Keidan[39] reported a case of an infant girl with fatal generalized vaccinia, failure of antibody production and absence of gamma globulin. Prasad's case[38] was a 30 year old white female suffering from repeated meningitis, pneumonia, generalized lymphadenopathy, hepatosplenomegaly and non-specific granulomatous lesions in liver and spleen. Zinneman[18] also reported a case of a 30 year old housewife with 35 attacks of pneumonia from 1942 to 1950. She had also splenomegaly and epitheloid cell granuloma without necrosis in the liver and lymph nodes. The latest report of this disease in female patients was by Collins.[36] Both cases had bronchiectasis and pulmonary infection. For acquired agammaglobulinemia, the sex incidence seemed not very important. Probably there is no sex preference. For example, Verschure's[16] series, 11 of 15 cases were female. From other reports[19, 27, 32, 35] more cases were found in males.

The onset of illness is also variable. The majority of patients had a history of recurrent infections for years. Since electrophoresis is a comparatively new procedure, it is not known whether agammaglobulin may develop right after birth, early in infancy or in later life. Follow-up studies suggest the possibility of a cyclic tendency in susceptibility to infection and alteration of serum gamma globulin level, as reported by Laski et al.[24]

The characteristic features of agammaglobulinemia are an extreme susceptibility to bacterial infections, poor or no antibody formation, lack of isoagglutinins, extremely low levels or absence of gamma globulin in spite of normal concentration of alpha and beta globulins, normal liver and renal functions and failure of antibody production in response to antigenic stimulation. There is also failure of long term antibiotic therapy to furnish adequate protection and excellent response to protective injections of human gamma globulin. The blood picture of these patients is variable. Transient or cyclic neutropenia, leukocytosis, arrested development

of neutrophils in peripheral blood and bone marrow, decreased or absence of plasma cells in bone marrow have been observed. Splenomegaly and hepatomegaly may or may not be present, but when found are usually moderate. Generalized lymphadenopathy in moderate or mild degree was observed in some cases. Bacterial studies may yield positive cultures from various sources. Infections commonly found in association with agammaglobulinemia are: purulent sinusitis, pneumonia, meningitis, acute arthritis, pyoderma, furunculosis, purulent conjunctivitis, otitis media and bronchiectasis. The most common causative bacterial agents are: pneumonococci, staphylococci aureus, hemophilus influenza and meningococci. Most of the cases appear to show a variability in susceptibility to bacterial infections. Severity and frequency of bouts of infection seem to vary periodically. Three or four fatal cases can be found in the literature.

As mentioned above, we believe it important to differentiate this condition from cases suffering from agammaglobulinemia or hypogammaglobulinemia secondary to systemic diseases, such as nephrosis, nutritional disturbance, fulminating infections, multiple myeloma and other neoplastic conditions and certain endocrine disorders. Sometimes it is not possible to say whether the agammaglobulinemia is congenital or acquired. Since the exact etiology and pathogenesis have not been completely worked out, one may find cases in which etiologic classification is not practicable. Careful search for a possible primary cause for agammaglobulinemia may be worthwhile. Another type of case which should be differentiated from so-called primary congenital agammaglobulinemia is characterized by a congenital defect of gamma globulin metabolism with recurrent hypoalbuminemia, edema and possibly general anasarca. There is nearly complete absence of gamma globulin. These patients are rarely ill, have positive Shick and Dick tests, and negative scratch tests with various antigens. They are particularly resistant to infections, in contrast to susceptibility to recurrent bacterial infections in true cases of congenital agammaglobulinemia. Marked leukopenia and neutropenia were found in these patients. The gamma globulin level may vary from almost complete absence to a significantly low figure. Ordinarily, gamma globulin is temporarily higher in normal newborn infants than in the mothers.[73, 74] According to the study of Orlandini,[40] in the first month of life, gamma globulin is often decreased to about one-third the value found at birth. Until three months of age there is no further change, after which there is a slow rise. At two years of age, adult values are closely approximated; at about five years of age, the level reaches the adult value.

The following table represents average normal figures of gamma globulin level in serum as determined by electrophoretic methods.

Author	Year	Cases Studied	Percentage of Total Serum Protein					
			Albumin	Alpha 1	Alpha 2	Beta	Gamma	Fibrigen
Dole[65]	1944	15	63.0	4.6	7.2	12.1	11.0	5.1
Armstrong et al.[66]	1947	20	55.2	5.3	8.7	11.0	6.5	
Verschure[6]	1954	72	64.0			9.0	16.0	
Antweiler[70]	1950		63.0			14.0	14.0	

In adults, gamma globulin varies from 0.5 to 0.8 gm. per 100 ml. of blood or average about 9 to 11 per cent of total serum proteins. In premature babies, the value is 0.7 to 0.9 gm. by Jager's[59] estimation; normal infants have an average figure of 0.68 gm.

From electrophoretic studies in agammaglobulinemia, the serum gamma globulin level varies from 0 to 0.2 gm. per cent. Values less than 0.2 gm. obtained by fractionation may not be detectable by electrophoretic method.[29] Immunochemical analyses will detect amounts less than 30 mgm. per cent of gamma globulin;[13, 24] Levin[4, 44, 45] reported close correlation of gamma globulin data obtained by paper electrophoresis, Tiselius and salt fractionation technique. However, since the latter is intricate, expensive and time-consuming, it is impractical for wide routine clinical use. Paper electrophoresis may give at least semi-quantitative or pure qualita-

tive results quite adequate for clinical use. It is inexpensive and easy to perform and may well become an additional routine facility of most clinical laboratories.

It should be emphasized that cyclic changes of gamma globulin level do occur in some patients; therefore, single determination of the gamma globulin level is not sufficient.

Pathologically, two autopsied cases of agammaglobulinemia with bronchiectasis were recently reported by Collins.[36] Lymphoid structures showed no germinal centers, and no plasma cells could be demonstrated in any tissue. It is quite compatible with the studies of Good,[21, 25, 31] Craig,[23] and others.[12, 13] The lymph nodes removed from these patients showed rather narrow cortex, small, ill-defined follicles, absence of germinal centers and pre-plasma cells and plasma cells. The reticuloendothelial cells of the peripheral and central sinusoids in these nodes were swollen. When examined by the fluorescent antibody of Coon's technique, administered antigenic material was easily demonstrated in these lymph nodes, but neither gamma globulin nor specific antibody could be found. After antigenic stimulation in a normal individual, these lymph nodes histologically showed an increase in the breadth and cellularity of the nodal cortex and the development of well-defined follicles having active germinal centers. The medullary cords were increased in prominence and large numbers of plasma and pre-plasma cells appeared in both the cortex and medullary regions. Sections of these lymph nodes examined by fluorescent antibody technique revealed gamma globulin in various cells and in the interstitial fluid; specific antibodies could be easily demonstrated in the reticuloendothelial cells or in the cells of plasma cell series. Most of these reported cases showed marked decrease in activity of lymphoid tissue. Two cases were reported with marked lymphoid hyperplasia and non-specific granulomatous lesions in the liver and spleen, as well as in the biopsied lymph nodes. In our patient, nonspecific lymphoid hyperplasia was demonstrated; the plasma cells were not elevated as would have been expected as a normal response to bacterial infections. Aside from changes in lymph nodes, similar decreases of activity of plasma cells can be observed in the bone marrow. Generally speaking, other important organs, such as liver, kidney, endocrine glands, revealed no significant anatomical or histological changes, aside from changes due to secondary bacterial invasions.

All these patients showed lack of production of antibodies to autogenous pneumococcal vaccine, as well as commercial pneumococcal polysaccharides. Immunizations were attempted in many cases without success. Schick test remained positive in spite of additional diphtheria toxoid injection. No circulating typhoid or paratyphoid antibodies were present after typhoid and paratyphoid A and B antigen inoculation. Some cases failed to produce complement fixation antibodies in spite of recurrent attacks of mumps. Skin test with tuberculin and histoplasmosis antigens were negative. None of these patients possessed significant amounts of antibody against streptolysin, streptococcal hyaluronidase or streptococcal desoxyribonuclease. In addition, Forsman antibody, cold agglutinins and complement fixing and virus neutralizing antibodies, commonly found in the serum of normal patients, were lacking in these patients. Isoagglutinins against heterologous blood group cells were completely absent in some patients, and low titers in others. Good[34] carried out an interesting and also very important experiment in a case of agammaglobulinemia. A successful homovital graft of skin was made which survived for 11 months (time of publication). A normal individual was unable to take a skin graft obtained from that patient with agammaglobulinemia. The success of homovital graft obtained with this patient is far better than previous unsatisfactory attempts using many agents, such as X-ray irradiation, ACTH, cortisone, antihistamines, desensitization, etc. tried in an attempt to suppress antibody formation against the skin graft. This result was also supported by the recent report of some success with kidney transplants[63] in seven nephritic patients in whom gamma globulin and antigen-antibody mechanism might be suspected of being somewhat altered.

With the availability of human gamma globulin and various antibiotic agents, the prognosis of these patients has become more encouraging. Most patients had dramatic and prompt response to the administration of adequate doses of antibiotics. Gamma globulin is given in dosage of 0.1 gm. per 50 kg. of body weight both for therapeutic and prophylactic purposes.[27, 75] The majority of cases can be satisfactorily controlled by the parenteral administration of gamma globulin 10 to 20 cc. every four to five weeks. Antibiotics alone may be insufficient for prophylactic protection against infections. In our patient, gamma globulin administration was started January, 1955. At the present time she is free from recurrent infection and gaining weight steadily. This is in contrast to the experiences of the last two years during which time she was rarely free of infection, and gained little weight. However, insufficient time has elasped to permit conclusive evaluation of results. In management of any case, possible causes of agammaglobulinemia must be borne in mind. Consideration of nutrition, especially proteins and vitamins is obviously important.

The etiology and pathogenesis of agammaglobulinemia are not very clear. There is much information about factors which may deplete serum gamma globulin level in many physiological conditions such as malnutrition,[1, 43, 49] endocrine disturbances,[53, 72] infections, neoplastic conditions[1, 49] and nephrosis.[60] Before diagnosing a so-called idiopathic or essential or primary agammaglobulinemia, one should rule out these conditions.

From the studies of the half-life of labeled gamma globulin in these patients,[12, 13, 17] the results showed no increased degradation of labeled homologous gamma globulin. It seems that the defect is chiefly due to a disturbance in the manufacture of gamma globulin rather than an increased destruction.

In man, antibodies occur chiefly as gamma globulin. This is evident from the wide variety of antibodies present in the gamma globulin fraction obtained by low temperature, low salt ethanol fraction of normal human plasma[68] and by the notable increase in gamma globulin accompanying many chronic infections such as tuberculosis, syphilis, kalaazar, lymphogranuloma inguinale, granuloma inguinale, leprosy, malaria, typhus, lobar pneumonia and many allergic and collagen diseases. Purified Wassermann antibody usually migrates with a mobility intermediate between beta and gamma globulins;[69] therefore, a small amount of antibody may be also present in the beta fraction. The site of antibody formation is also a controversial question. Evidence suggests that plasma cells, possibly the reticuloendothelial system, spleen and lymph nodes may be the sites for antibody formation. Whether or not gamma globulin comes from other tissues aside from the above-mentioned organs is still under investigation. Correlating the facts that agammaglobulinemic patients showed high susceptibility to bacterial infections, poor or lack of antibody formation, and suppression of activity of plasma cells, it is quite possible that plasma cells play a very important role in the natural antigen-antibody mechanism of the body. The reason for possible suppression of the activity of plasma cells is unknown. Some authors postulate a mechanism similar to that of congenital afibrinogenemia and hemophilia. Such patients should have symptoms as soon as the circulating maternal gamma globulin has been exhausted in their early infancy. It is difficult to explain those cases in the older age group in which no other causative agent could be demonstrated. Another group of authors consider agammaglobulinemia as a state of immunological paralysis or paresis as suggested by Felton[61] from his animal experiments. By this concept, the immunological mechanism may be blocked for some unknown reasons and the patients can no longer respond normally to antigenic stimulants.

Nutritional deficiency may result in decreased antibody formation. Vitamin deficiency may also suppress antibody formation but rarely causes any alteration of serum protein concentration.[64]

Lastly, we should consider the possible role of the adrenal gland in this disease. In view of studies of decrease of gamma globulin and increased susceptibility to bacterial infections in

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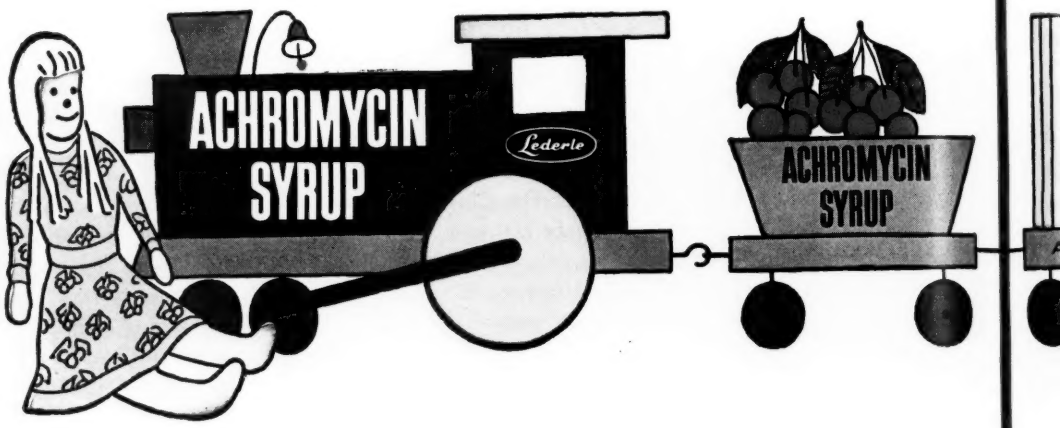

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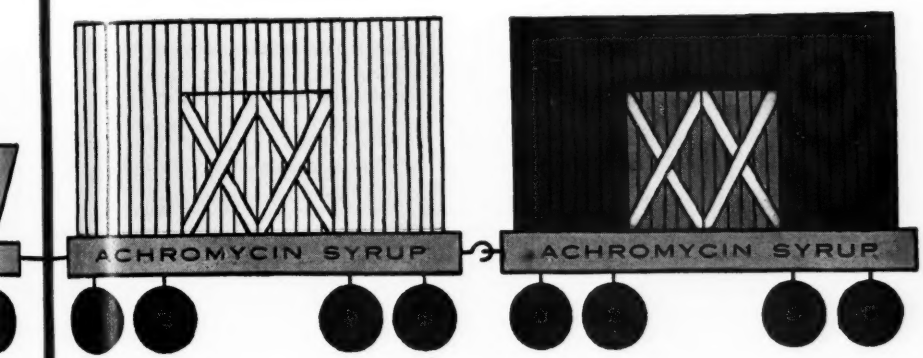

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adrenal disorders,[53, 72] and the well known phenomenon of suppression of antibody formation by ACTH and cortisone, studies of adrenal function in seven patients were carried out by Good.[33] Most of the patients showed quite normal adrenal function as determined by urinary 17-oxy-steroid excretion.

Thus, agammaglobulinemia may be a congenital defect involving deficient gamma globulin production, and, in some unknown way, related to a suppression of the activity of plasma cells. Further investigation is indicated to determine whether bacterial infections, viral infections, or even chemotherapeutic agents, including antibiotics, may be involved in the suppression of plasma cell activity and alteration of gamma globulin level in the serum.

Since the first report of agammaglobulinemia many achievements have been made in the field of immunology. We hope one day we will be able to use artificial means to produce so-called immunological paresis or paralysis and inhibition of antibody formation in order to solve some immunological problems, and perhaps make homovital grafts possible for therapeutic purpose.

SUMMARY

1. A case of hypogammaglobulinemia with recurrent bacterial infections in a seven year old girl is reported.

2. Available literature about this disease is briefly reviewed and discussed.

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Component Medical Societies

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.
Journal Representative

At a regular meeting of the Allegany-Garrett County Medical Society, held at the Nurses' Home of the Memorial Hospital, Cumberland, Maryland, Dr. Allan E. Trevaskis, Allentown, Pennsylvania, addressed the Society. The title of his paper was "Eradication of Scars by Plastic Surgery."

Dr. Allan E. Trevaskis, *Speaker*; Dr. Richard W. Trevaskis, operating projector at the April meeting of the Allegany-Garrett County Medical Society.

Dr. Trevaskis gave an informative talk, which was participated in by the members of the Medical Society during a question and answer period. Dr. Trevaskis was assisted by his father, Dr. Richard W. Trevaskis, who practices in Cumberland, in showing slides for his talk. His brother, Dr. Richard W. Trevaskis, Jr. was also in the audience.

Dr. Trevaskis is a graduate of Harvard University and of the University of Maryland Medical School. He served an interneship in Allentown Hospital and a surgical residency in Baltimore, Maryland. He is the author of several articles in leading Medical Journals, on Plastic Surgery.

DEPARTMENT OF MEDICAL DEFENSE FOR ALLEGANY COUNTY

DR. LESLIE E. DAUGHERTY, *Medical Director*
7 Washington St., Phone 2612

On February 14, 1951, your Director for Medical Services of Civil Defense of Allegany County, was directed to establish under the Maryland Civil Defense Plan, emergency hospitals. To this effect, it was decreed that the Medical Services have the first priority in requisitioning buildings for use as emergency hospitals.

The hospital unit has recommended the following policy with regard to the establishment and operation of emergency hospitals:

Existing general hospitals should function as base hospitals. These hospitals should be responsible for the expansion of their own facilities to the maximum capacity and in addition be responsible for the establishment and operation of emergency hospitals. Their responsibility for establishing additional beds within the existing hospitals and in emergency hospitals should be based on their normal bed capacity related to the total need.

Under this policy, existing hospitals are responsible for organizing cadres for emergency hospitals and will have an active interest in organizing and training of personnel for the cadres. Emergency hospitals will, therefore, function as satellites of existing hospitals on a pre-planned basis with personnel accustomed to working together.

This policy should facilitate the assignment of personnel, the preparation of supply lists and the acquisition and disbursement of supplies.

To this end on March 1, 1951, the following emergency hospitals were designated:

The already existing Memorial Hospital and the Sacred Heart Hospital, which formerly was called the Allegany Hospital, were recommended as regular and established operative hospitals. Emergency hospitals to be attached to these existing hospitals were established at the Fort Hill High

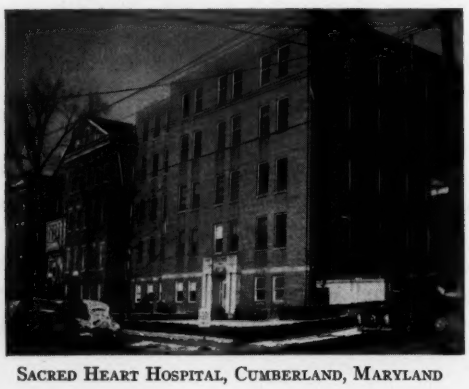
MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND

School, as a satellite to the Memorial Hospital, and the Frederick Street Elementary School, as a satellite of the Sacred Heart Hospital.

These hospitals have a paper plan with complete personnel, consisting of well trained surgeons and medical men, together with all trained lay personnel to carry on as a functioning emergency hospital in time of disaster or conflagration; whether it be in wartime or peacetime.

The present bed capacity of Memorial Hospital is two hundred and fifty adult beds and thirty-five bassinets. The Sacred Heart Hospital, one hundred and thirty-four adult beds and sixteen bassinets. Emergency hospitals, Fort Hill High School, eight hundred beds and Frederick Street Elementary School, three hundred beds.

It is planned that emergency auxiliary hospitals will care for all of those injured requiring hospital care in an emergency and the civil population will continue to be taken care of at the already existing



SACRED HEART HOSPITAL, CUMBERLAND, MARYLAND

hospitals. All those injured persons able to walk and that can be cared for in their homes, will be routed directly from Casualty Clearing Stations to their homes, where they will be attended by their family physician or emergency physician designated to do that service. Babies born, in so far as possible, will be in their own homes or emergency homes established for that purpose.

It is expected that sick and injured will have to be taken care of who are refugees from other bombed out areas, such as the larger cities to our East and the West. We no longer can think in terms of our own civilian population, but we must think of number possibly in the neighborhood of a 150,000 to be cared for.

Our transportation will be taxed to the utmost and therefore it is necessary that each of us work out a plan, so that in emergency we have some definite place to go and some definite plan of action to care for ourselves, for our relatives and we must even take into consideration not only our friends, but our newmade friends, because in wartime barriers are broken down, peoples become one in all-out warfare.

Radiation and disease from germ warfare will play a prominent part. We cannot longer think of war injuries being in terms of fractured bones, torn and twisted bodies, but from a more deadly standpoint must we consider radiation sickness, poisoned water, intestinal disease from poor sanitation and mass hysteria. The latter will be greatly prevented by careful and mythical planning for our defense.

It will be necessary for all of us at some time, to take part in the aid and safety of all of us and now is the time for each of us to ally ourselves with some organization in the defense of our personal well being. Select now that unit for which you are most suitable. Contact your Red Cross, your Casualty Clearing Headquarters, the Nurse's Aid Organization attached to our two hospitals, or any nurse in your community. Do it now, for your own safety and the safety of your loved ones.

BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D.
Journal Representative

The Annual Meeting of the Faculty has come and gone as this is written. It was a good meeting and the City Society is pleased with the response to the Cocktail Party and Ball. President Koontz can

take a great deal of credit for inaugurating the first, and our Auxiliary for carrying on so well with the second.

The Executive Board at its meeting in April considered the several pending projects previously reported. Progress had been made with some of them, most are in suspended animation.

The Board agreed to encourage the Association of American Physicians in their Essay Contest. The Title is "*The Advantages of Private Medical Care*" this year, the ninth, of competition among high school students for prizes ranging from one thousand dollars for first prize through five hundred, one hundred, and three of twenty-five dollars each. Literature is sent to interested school groups when the contests open each Fall.

Dr. Louis F. Klimes requested relief from the chairmanship of the Committee on Emergency Medical Calls. Dr. John M. Scott has been appointed to take over this important public relations position.

BALTIMORE COUNTY MEDICAL ASSOCIATION

WILLIAM A. PILLSBURY, M.D.
Journal Representative

The April meeting of the Baltimore County Medical Association was held April 20, at the Sheppard and Enoch Pratt Hospital. Following the business meeting, Dr. John D. Patton presented "Shock Therapy and New Drugs in the Treatment of Psychoses."

GENERAL PRACTICE SECTION CONCLUDES FIRST YEAR

KENNETH KRULEVITZ, M.D.
Secretary

The newly formed General Practice Section of the Baltimore City Medical Society completed its first year of organizational work. A number of important matters were discussed during the monthly meetings which were held at the Medical Chirurgical Building. Several highly stimulating lectures were given during the course of the year on subjects of interest to the general practitioner. Dr. Jacob Conn gave a lecture-demonstration with patients on the use of Hypnosis in the treatment of various psychiatric disturbances. A panel discussion was presented by psychiatrists from the Psychiatric Institute of the University of Maryland Medical School. This group of physicians gave practical methods for the general practitioner to use in his everyday treatment of functional disturbances.

Mr. Reginald H. Dabney, Director of Maryland Hospital Service and Maryland Medical Service spoke to the family doctor regarding the problems of Blue Shield and Blue Cross. This lecture gave the family doctor a better insight into the problems which exist in running the Blue Cross and Blue Shield program. One of the outstanding lecturers of the year was Dr. Harry Gordon, Chief of the Pediatric Division of Sinai Hospital, who spoke on the care of the newborn infant. Finally, Dr. Louis Krause spoke to the physicians about their duties to the patient and the role which the family doctor takes in caring for 90% of the general population. This was a most interesting and informative lecture and many problems were discussed with Dr. Krause which were of help to the physicians present. Dr. Krause was selected as the First Honorary General Practitioner of the General Practice Section of the Baltimore City Medical Society.

At the final meeting of the Section there was an election of officers for the term 1955–1956. Dr. Kenneth Krulevitz was elected *President*, Dr. Ellsworth E. Cook elected *Vice-President*, and Dr. Joseph S. Blum elected *Secretary-Treasurer*.

The following committees were formed: Hospital Privileges Committee headed by Dr. Charles M. Kerr; Program Committee: Dr. Louis S. Blum; Publicity Committee: Dr. Marion Friedman; Public Education Committee: Dr. Benjamin Kader; Membership Committee: Dr. Ellsworth Cook; Liaison Committee headed by Dr. Louis Maser.

In order to carry on more successfully the goals of the organization, it was felt that membership dues would be necessary. It was decided to tax each member $5 per year in order that this money might be used to obtain interesting speakers for the coming year.

One of the goals of the General Practice Section of the Baltimore City Medical Society is to help every General Practitioner in the city of Baltimore obtain hospital privileges so that the family doctor may have the opportunity to become associated with a hospital, thereby allowing his patient to have the privilege of being treated by his own

family doctor. Any physician who desires to learn more about obtaining hospital privileges is urgently invited to attend these forthcoming meetings. It is sincerely felt that this General Practice Section of the Baltimore City Medical Society has an important role to fill in helping the family doctor help his patients. Once again a request is made that all general practitioners attend future meetings which will start September 15, 1955.

CECIL COUNTY MEDICAL SOCIETY

M. H. SPRECHER, M.D.

Journal Representative

Physicians should be more active in world affairs since medicine has no language barriers, and because of their aims and purposes, they can effectively work for understanding and peace. Relationship with our neighbors to the North and South and with countries of the West and the Near and Far East can be improved by the plans in operation through which selected men from other countries are trained in America to return to their homes to teach and practice.

Such were the thoughts of Dr. I. Ridgeway Trimble, Associate Professor of Surgery at the Johns Hopkins Medical School, and expressed tangentially from his prepared address, "Chronic Relapsing Pancreatitis." His talk pointed out the gratifying relief that can often be given to patients suffering from this condition.

Almost the entire membership of the Cecil County Medical Society, along with representatives from Bainbridge Training Center, attended the dinner meeting held at the Wellwood Club, Charlestown, in May.

Dr. R. C. Dodson, President of the Society, announced a committee to function between meetings and during the summer months.

FREDERICK COUNTY MEDICAL SOCIETY

L. R. SCHOOLMAN, M.D.

Journal Representative

The regular April meeting was held on the 19th. The speaker of the evening was Dr. John Parks, Professor of Obstetrics and Gynecology at George Washington University, who spoke on the medical and surgical complications of pregnancy. After the scientific program there was a long discussion on the Salk polio vaccine. The Society voted to go on record endorsing the priority classification set-up by the Maryland Board of Health and further directed that this endorsement be published in the County newspaper.

HOSPITAL NEWS

The Medical Department interviewed a well qualified dietitian with a view of establishing an out patient diet instruction service. All those present were pleased with the plan presented and were happy in the thought that the instruction would be in such capable and sympathetic hands.

The April C.P.C. was held on the 12th. The case was a rapidly progressive malignant hypertensive who lived a year after developing a dissecting aneurysm. The cause of death was a hemorrhage into the pons rather than the dissecting aneurysm.

MONTGOMERY COUNTY MEDICAL SOCIETY

MAYNARD I. COHEN, M.D.

Journal Representative

"Pathological Basis for the Management of Intracranial Vascular Lesions," an illustrated talk with third dimensional slides, highlighted the May meeting of the Montgomery County Medical Society, held Tuesday, May 17, 1955, at Olney Inn, Olney, Maryland. The speaker was Doctor Arthur Morris.

Doctor Eugene Richard Inwood has become an active member of the Society, and Doctor Leonard M. Dub, an affiliate member.

The Montgomery County Health Department is undertaking a tuberculosis survey of children entering school in the coming year. Accordingly, the Executive Committee of the Society recommended that members patch test all such children. Those who have not been patch tested by their physicians will be tested in the schools. It is understood that the Health Department will notify the private physician of positive reactions and that the survey results will be reported.

The Board of Censors reminded the membership of the Society that "it is a breach of ethics to allow one's name to appear in annuals, directories, or lists of physicians by subscription." It is absolutely so if in addition, one's phone number and/or office hours appear, and particularly when the space is bought.

"The Board of Censors intends to enforce the rules pertaining to such matters in order to protect the membership.

"This in no way is to be construed as preventing a member's name from appearing in a mixed list of laymen and physicians as private sponsors, or in a membership list of philanthropic organizations, or in bona fide medical listings as are found in telephone company directories.

"It is suggested that if one wishes to buy space in annuals, directories, or similar publications that the space read 'Compliments of a Friend'."

WICOMICO COUNTY MEDICAL SOCIETY

WILLIAM S. WOMACK, M.D.
Journal Representative

The last regular monthly meeting of the Wicomico County Medical Society was held on April 30, 1955 in the Watson Memorial Building. It is of note that it was an unusual meeting in that Dr. Harlon Farr, Assistant Clinical Attending Surgeon on Head and Neck Service, and Dr. Richard D. Brasfield, Assistant Clinical Surgeon on Stomach and Mixed Tumor Diseases of New York City were present in this city on April 30 to conduct our County Medical Society meeting. These men were from Memorial Hospital, New York, New York.

At 6:30–7:00 p.m. on that date these men held a very interesting television program on cancer for the lay personality of Salisbury. At 8:30 p.m., as guest speakers at the County Medical Society meeting, they gave intensely interesting talks about cancer, which were illustrated by lantern slides. This was followed by an active question and answer session.

The routine business was taken care of in the usual manner and a good attendance was had.

SEMIANNUAL MEETING
Medical and Chirurgical Faculty

OCEAN CITY, MARYLAND
Friday, September 16, 1955

Headquarters—Commander Hotel

Morning Meeting—House of Delegates and Woman's Auxiliary
Luncheon—One of those well-remembered clam bakes on the beach
Afternoon—Scientific Session and other features

Plan the *Semiannual Meeting* in Ocean City as part of your vacation. Make your Hotel reservations now!

Necrology

A. S. CHALFANT, M.D., *Chairman*

Memoir Committee

George C. Basil, M.D.

1902–1954

Dr. Basil graduated from St. John's College in 1920, the University of Maryland School of Pharmacy in 1923, and from the University of Maryland Medical School in 1927. He served internships at Mercy Hospital and Bon Secours Hospital. In company with his wife, Mrs. Maude Stanley Basil, he spent three years in Chungking, China, where he did research work in foot and mouth disease and in intestinal parasites. His experiences there formed the background for his book, "Test Tubes and Dragon Scales," published after his return to practice in Annapolis in 1932.

His post-graduate work was continued in medicine and surgery in the University of Maryland. In addition, he gave time to The Johns Hopkins Hospital and Medical School where he was an assistant in medicine. Dr. Basil was on the Medical Staff of the Anne Arundel County General Hospital, Past President of the Anne Arundel County Medical Society, member of the American Medical Association, the Southern Medical Society and the Randolph Winslow Surgical Society. Dr. Basil's practice was general in the broadest sense, including an active surgical and obstetrical practice as well as keeping in touch with the modern developments of medicine. His astounding fund of mercurial energy drove him to include many outside interests, including several fraternal orders as well as important business connections and even left a residue for yachting and hunting and as a hobby playing an organ in his home.

Challenged as are all general practitioners, to be all things to all men, Dr. Basil took this to mean all things to all men at the same time and, though very nearly succeeding in this impossible task, his early and sudden death is a warning to men of lesser capacity.

A host of patients miss his brisk and cheery visits and with his grieving family are shocked by the sudden withdrawal of this vibrant and devoted life.

Clyde A. Clapp, M.D.

1880–1955

Dr. Clyde Alvin Clapp was born May 29, 1880, at Chatham, Ohio, and died in Baltimore, Maryland, April 9, 1955. Between these dates was spent a full, useful and successful life. He graduated in medicine in 1902, from the old Baltimore Medical College. After a few years of general practice, he became a specialist in eye, ear, nose and throat in association with the late Dr. J. Frank Crouch. Later, as his interest became centered in ophthalmology, he confined his work to that field, and became a distinguished authority in his chosen specialty. For many years he held simultaneously the rank of Professor of Ophthalmology in the University of Maryland Medical School and of Associate Professor of Ophthalmology in The Johns Hopkins Medical School, being one of the small group who won recognition on the faculty of both schools.

Among his professional associations was membership in The Baltimore City Medical Society, the Medical and Chirurgical Faculty of Maryland, the American Medical Association, the American College of Surgeons, the American Ophthalmological Society, and the Ophthalmological Society of the United Kingdom. He was on the staff, and at one time chairman, of the Baltimore Eye and Ear Hospital.

Dr. Clapp was a frequent contributor to the medical literature, his first piece of investigation being done while still a medical student, and his collected reprints being sufficient to comprise several bound volumes. In 1934, he published a book, "Cataract, Its Etiology and Treatment," which attracted wide favorable comment, and was described as the

authoritative text in English at that time. Beginning in 1910, he made frequent visits to the leading clinics of Europe and the British Isles, establishing not only professional but personal friendly relations with many of the world's leaders in his chosen field. He was a frequent and welcome visitor at Moorfield's, the Royal Ophthalmic Hospital of London, and knew well such British figures as Sir John Herbert Parsons, Mr. Treacher Collins, Mr. Maurice H. Whiting and Sir Stewart Duke-Elder.

But Dr. Clapp's travels were not exclusively for purposes of professional enlightenment. With Mrs. Clapp he paid many visits that included all the continents of the World and that gave wide opportunity for the exercise of his hobby of photography. This resulted in a husband and wife team of colored movie and travelogue entertainment of almost professional competence. They enjoyed giving these entertainments to many groups, including various medical societies.

Dr. Clapp's interest in organized medicine was life-long and genuine. Not only did he support the activities of his own specialty on a local and national scale, but he was interested in the problems and policies of the whole profession and was a regular attendant at the general meetings. It may justly be said that he was an ornament to medicine. Further than that he was a loyal friend, a good citizen and a high-principled, conscientious physician. His passing means a great loss to the profession and to the whole community.

Howell J. Hammer, M.D.

1871–1954

Dr. Hammer was one of that great old tradition who thought that all was not too much to know about Medicine. Graduating from the University of Maryland School of Pharmacy in 1891, he returned after years of practical pharmacy to graduate from the University of Maryland Medical School in 1916. He was active in general practice as well as continuing with a part-time interest in his pharmacy. In later years, he was grieviously handicapped with glaucoma, so that his vision deteriorated to the point where regular practice was very difficult. He refused to accept retirement or sympathy. Even after the death of his devoted wife in 1940, he lived alone, having no children.

For the last fifteen years, he was never able to get out but many friends cared for him and he had a regular succession of old patients who came to talk over their problems, medical and personal. He had always been a very systematic person keeping meticulous notes in longhand. Living to the advanced age of eighty-three none of his own generation survived in his family. But ten nieces and eight nephews mourn his passing and like to remember him as he was known from his graduation year book in 1916, "As kind as kings on their coronation day."

John A. Leutscher, M.D.

1870–1955

Dr. John A. Leutscher, a member of The Johns Hopkins Medical Society, the Medical and Chirurgical Faculty, American Trudeau Society, National Tuberculosis Association, Fellow of the American Medical Association, died on February 4 after an illness of two months at The Johns Hopkins Hospital, age eighty-four.

Dr. Leutscher was born April 10, 1870 in Prairie du Sac, Wisconsin. His parents came there from Davos, Switzerland. He graduated from State Normal School, Whitewater, Wisconsin, in 1893. He received a B.S. degree from the University of Wisconsin in 1895 and an M.D. from The Johns Hopkins University in 1899.

His internship was at The Johns Hopkins Hospital, 1899–1900; House Officer, Boston City Hospital, October 1900 to April 1901. He married C. Elizabeth Tumbleson, July 16, 1904 who died in 1936. In 1947, Dr. Luetscher married Matilda R. Luetscher, who survives him, also a son Dr. John A. Luetscher, Jr., Associate Professor of Medicine in Stanford, and two grandsons.

Dr. Luetscher was Assistant in Medicine, 1905–1907; Instructor in Medicine, 1907–1913; Associate in Medicine, 1913–1914; Associate in Clinical Medicine, 1914–1918—all at The Johns Hopkins University. He served as U. S. Contract Surgeon to examine the National Guard of Baltimore for tuberculosis in 1917. He was on the Staff of Church Home and Infirmary and Union Memorial Hospital. He worked on several research projects in Bacteriology at Hopkins until 1918 when he left to devote time to private practice.

Dr. Leutscher lived a full and useful life. His family and friends will remember his philosophy of life. "Look to this Day! For it is Life, the very Life of Life. Yesterday is but a Dream, And Tomorrow is only a Vision, But Today well lived makes Every Yesterday a Dream of Happiness, and every Tomorrow a Vision of Hope. Look Well, therefore, to This Day!"

William Schulze, M.D.

1876–1955

Dr. William Schulze, 68½ West Franklin Street, died at his home March 14, 1955, after a long illness, age seventy-nine years.

Born in Monroe, Louisiana, he was the son of the late John and Hannah Schulze.

He graduated in medicine from George Washington University, Washington, D. C. in 1904, and practiced his profession in Monroe, where he was city physician for twelve years and a surgeon for the Iron Mountain Railway.

Dr. Schulze accepted the position of medical examiner for the Western Maryland Railway in Hagerstown in 1917. He held that position until 1929, when he retired because of ill health.

He was made an emeritus member of the Washington County Medical Society and the Medical and Chirurgical Faculty in 1950.

BOSTON CLINICAL MEETING
AMERICAN MEDICAL ASSOCIATION
November 29–December 2, 1955

All persons who desire a place on the lecture program at the Boston Clinical Meeting of the American Medical Association are urged to communicate immediately with the Chairman of the Program Committee—Theodore L. Badger, M.D., % Massachusetts Medical Society, 22 The Fenway, Boston 15.

Applications for space in the Scientific Exhibit are now available and will be sent on request. Exhibits will supplement the lectures as far as possible, and should portray subjects of a broad general interest. Requests for applications should be sent to the Secretary, Council on Scientific Assembly, American Medical Association, 535 N. Dearborn Street, Chicago 10, Illinois.

Library

"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *ibn Tibbon*

LIBRARY CHATTER

Of late, it seems, we've been celebrating Christmas every day in the library! Faculty members have been unusually generous and we have received a number of important gifts since the last time "Library Chatter" appeared.

Dr. Richard T. Shackelford, assistant professor of surgery at Hopkins and member of the Baltimore City Medical Society, presented us with a copy of his three volume work on "Surgery of the Alimentary Tract" published this year by Saunders. "The formidable task of revising the great Bickham text on Operative Surgery was approached," Dr. Shackelford says in the preface, "with a considerable amount of trepidation." After Dr. Bickham's death in 1924, Dr. C. L. Callander was preparing a second edition but died with his revision unfinished. Then, in 1949, Dr. Shackelford agreed to complete the revision in regard to the alimentary tract. "I anticipated," he says, "that I could complete the job in a year. It is now, quite obviously, six years later." He re-wrote all that Dr. Callander had done, described and evaluated the new procedures made feasible by new knowledge—and found that instead of the expected two volumes he had produced triplets. We were delighted to receive the book and our pleasure in having it increases the more we use it. Everything we have looked up in it has been there! And not only included, but described so thoroughly and explicitly that our search for information stops, as well as begins, right there. In the library we are also particularly grateful for the fact that the index is in all three volumes. We are not handicapped in using volumes one and two because the third, and index volume, is out as so often happens.

Dr. Manfred Guttmacher, also a member of the Baltimore City Medical Society, has given us two of his books which we have wanted for some time, "Psychiatry and the Law" and "Sex Offenses." Both were published by Norton, in 1952 and 1951 respectively. The latter book represents the fourth series of Gimbel Lectures; the topic, its author says, is "of pertinent nation-wide interest and importance" and he has presented it "from the point of view of the clinician, working in a criminal court," rather than from that of the philosopher or social reformer.

Dr. A. Dougall Young, Baltimore City, gave us the first publication in the American Monograph Series, a series "intended to bring to the medical profession the practical results of research in special fields of medicine." This is Dr. Howard C. Moloy's "Clinical and Roentgenological Evaluation of the Pelvis in Obstetrics," published by Saunders.

Dr. William R. Dunton, who has always been a good friend to the library, provided the first chapter of the symposium entitled "Principles of Occupational Therapy" and presented us with a copy of the book in its second edition, published by Lippincott in 1954. By nineteen different contributors, it includes therapy for the mentally ill as well as those with physical disabilities.

Dr. Bertram Bernheim, Baltimore City, sent the library a substantial check for the purchase of Dr. Shackelford's and Dr. Lewisohn's books, but most thoughtfully added that if we had those books we could use the check to purchase others. That's what we call a "free gift," no strings attached! Since Dr. Shackelford has given us his book, we will be able to buy something else in its place. "Breast Cancer and Its Diagnosis and Treatment" by Edward F. Lewison, Faculty member from Baltimore City, has been purchased in accordance with Dr. Bernheim's wishes. We are very grateful for Dr. Bernheim's kindness and are sure the other members of the Faculty are also.

Dr. Louis Krause, chairman of our Library Committee, gave us "The Physician and His Practice," planned as a "source book of information

regarding his career rather than as a detailed guide." We particularly liked Dr. Robert Buck's remarks on "Reading and Writing." He says, "The number of books and periodicals required by a physician in connection with investigative and teaching activities far exceeds the capacity of any private library. For this purpose a home medical library is no more feasible than a home research laboratory. . . . But a wide acquaintance with periodical literature is the only means of keeping up with what is going on in the profession." Then later he adds, "It is excellent practice to spend one afternoon a week, when such time is available, in the library of a hospital or other medical library with adequate facilities, reading and abstracting the current periodical literature." So come and try it in our air-conditioned journal room! The book is edited by Joseph Garland, editor of "The New England Journal of Medicine" and was published by Little, Brown.

Some anonymous benefactor left several biographies of physicians on the front steps one day, including an autographed copy of "I Swear by Apollo" by William E. Aughinbaugh. We do thank the donor and if he cares to identify himself, we'll be happy to acknowledge him by name.

Books which have been purchased for the library recently also include a number of important titles.

"Roentgen-Diagnostics" by Schinz and his colleagues is one. "For nearly twenty years, throughout its various editions, we have felt a strong need in the medical profession of the English-speaking world for the valuable material contained in the *Lehrbuch der Röntgendiagnostik*," Dr. James T. Case says in his preface to the English translation, complete in four volumes. "This admirable work," he goes on, "was . . . without equal in any language." It is monumental in a physical as well as intellectual sense: we hope the weight will not discourage borrowers.

We have acquired the three-volume "Urology," edited by Dr. Meredith Campbell and published by Saunders. Dr. Campbell declined to write a one-volume textbook of the subject "because today's progress and developments in this branch of medicine and its collateral fields are so amazing, rapid and variant that it is now beyond the scope of any one person to present all phases of this subject adequately." The completed work represents the collaboration of 51 contributors.

Another translation from the German is Sobotta's three-volume "Atlas of Descriptive Human Anatomy," done into English by Eduard Uhlenhuth, Professor of Anatomy at the University of Maryland. This work with its remarkable anatomical drawings was planned to meet the practical needs of physicians. We particularly welcome this new edition because the library had only one volume of the older English edition.

A rare and interesting addition to the Library is a copy of the dissertation of John O'Connor of Baltimore, entitled "An Inaugural Essay on Carcinoma or Cancer," for the degree of Doctor of Physic, which was submitted to the examination of Charles Alexander Warfield, M.D., President, and the Medical Faculty of the College of Medicine of Maryland on the 1st of May, 1812, and printed in that year, in Baltimore, by Benjamin Edes, corner of South and Market Street. The old and yellowed paper gives a fascinating air of age to the dissertation; but perhaps there is something timeless in the suggestion on page 20 that the increasing incidence of cancer might be due to increase of luxury in the higher ranks of society and the immoderate use of spirits in the lower orders! The work is dedicated to the Right Reverend John Carroll, Archbishop of Baltimore—but the Archbishop's title was changed in ink, apparently by O'Connor himself, to "Most Reverend" after the dissertation had been printed. Our copy has an inscription: "For the Rev. Mr. Moranville. With the compliments of the Author." The recipient was a French Catholic missionary who came to the United States in 1795, settled in Baltimore and became pastor of St. Patrick's church in 1801; that he was not one of those supporters of the *ancien régime* who "learned nothing and forgot nothing" appears from his founding of the first free school for girls in our city. As for John O'Connor, his dissertation was evidently accepted, for he got his degree in 1812—but died of yellow fever nine years later. In general, this is quite a "museum piece"—and we plan to put it on display in the Reading Room.

Sometimes we may visualize ourselves as creatures that live crawling on the bottom of an ocean of air. Two books—presented by the U. S. Air

Force—that suggest this view are "Flight Surgeon's Manual" and "Physiology of Flight"; they suggest, too, a world of the future when we will feel at home in the ocean above us—and when the physiology of flight will be at every doctor's finger-ends.

"The surgical profession," Dr. Gerald H. Pratt says in the preface to his "Cardiovascular Surgery," has been interested in developmental defects, lesions and diseases of the cardiovascular system as long as the art and science of surgery have been studied and practiced." In this enlargement of his earlier "Surgical Management of Vascular Diseases," Dr. Pratt aims to provide "a post-graduate review to the physician who physically cannot take post-graduate courses to acquaint him with recent knowledge in this rapidly changing field." He also hopes that it may aid in undergraduate teaching, for the subject, he states, "in our busy medical schools is left to be covered in part by other required courses." It was published last year by Lea and Febiger.

Among other recent additions of interest are the following:

Public Relations in Medical Practice, by James E. Bryan. Williams & Wilkins, 1954.

Surgical Pathology, by Lauren V. Ackerman. C. V. Mosby, 1953.

The Mechanisms of Disease, by Joseph Stambal. Froben Press, 1952.

Medicinal Chemistry, by Alfred Burger. Interscience Publishers, 1951.

Adventures in Physiology, by Sir Henry Dale. Pergamon Press, 1953.

We have also all the published symposia of the Microbiology Section of the New York Academy of Medicine.

CORRECTION

The legends were transposed for Figures 1 and 2, on pages 261 and 262, May 1955 issue of the MARYLAND STATE MEDICAL JOURNAL.

Board of Medical Examiners

REPORT ON CONGRESS ON MEDICAL EDUCATION AND LICENSURE*

ERASMUS H. KLOMAN, M.D.†

More was accomplished at the 51st Annual Meeting of the Congress on Medical Education and Licensure than at any other that I have attended in the past twenty years. This impression was shared by the representatives of both of our medical schools, The Johns Hopkins Medical School and The University of Maryland Medical School.

The meetings were held at the Palmer House from Sunday, February 6, 1955 through Tuesday afternoon, February 8, 1955. The Essentials of a Modern Medical Practice Act was reported upon by the Study Committee and a Panel Discussion was held which gave us considerable information in regard to our contemplated changes in the Maryland Medical Practice Act.

Most of the other sessions were confined to discussions of the future of the internship. We came away with the feeling that it is probable that graduates of foreign medical schools applying for hospital privileges in this country (eventually many will take the State Boards in the State where they would live) will be much more carefully screened. These men would be screened in the country from which they originate. The screening would not be done by the native country but by our own Consulate.

Such screening would comprise proof of eighteen years education, as well as an ability to speak English and a fair understanding of our country's customs. In this way, the candidates could be forewarned that their education in medicine and knowledge of English was insufficient to expect admission for study in our schools and hospitals.

A panel discussion with Dr. Stiles E. Ezell as Moderator and Walter Wiggins, M.D., Dean F. Smiley, M.D., and Dr. Edwin L. Crosby participating discussed the extreme desirability of establishing such a system. Additional screening by a Central Screening Organization, possibly in Chicago would establish whether or not an applicant needed to learn more English, or needed to learn more about the customs of our country, and, if so, he would be directed to a selected college for appropriate study.

Following completion of the prescribed study, the same screening organization would recommend the applicant to a Class A hospital for further medical education. After several years of such education and with proper recommendation from reliable physicians, these applicants could then be considered for examination by the various State Boards for Board licensure. It was also shown very clearly that it was not altogether the duty of the State Boards to do all of the screening.

It has been the thought of the Maryland Board that the medical colleges are just as responsible as the Board for rendering help to graduates lacking a properly qualified medical education.

To help solve this problem it was suggested and recommended that the medical schools form study classes for such foreign graduates. In this way, foreign graduates would obtain one or more years of additional education and thereby could be recommended as having medical knowledge comparable to that of graduates from our own schools.

It is thought by a great many States, and in fact it is the Law of many States, that all doctors expecting to stay in this country should be citizens before taking the State Licensing Board examination.

It was also stated that the National Board intends to discontinue examining foreign graduates. The Maryland Board is very thankful for this rule since in the past the old policy of the National Board created many serious problems from the local viewpoint.

We feel that we are obligated to the people of the United States, as well as to our own graduates, to have more careful screening of foreign graduates before they are accepted into hospitals for graduate training.

* Chicago, February 5 to 8, 1955.

† Dr. Kloman retired June, 1955, after thirty-two years as a member of the Board of Medical Examiners of the State of Maryland.

Health Departments

BALTIMORE CITY HEALTH DEPARTMENT

Intervals Between Polio Vaccine Shots

A Letter to Physicians

May 13, 1955

Dear Doctor:

The City Health Department has been receiving from certain Baltimore physicians questions in regard to effective intervals between first and second dose inoculations of the new Salk Poliomyelitis Vaccine, inasmuch as there has been a temporary slow-down on this city-wide program.

In connection with the above, I am anxious to share with you at this time a joint statement recently prepared by the Baltimore City Health Department and the Maryland State Department of Health after consultation with the State Technical Advisory Committee on Poliomyelitis. You will remember that the members of the Technical Advisory Committee are Dr. Howard A. Howe, Dr. David Bodian, Dr. Thomas B. Turner and myself.

The text of the joint statement on this matter is as follows:

"Following a meeting with the Technical Advisory Committee on Poliomyelitis to the Maryland State Department of Health held on May 9, 1955, the Maryland State Department of Health and the Baltimore City Health Department issued a joint statement reaffirming the decision to follow the recommendation of the United States Public Health Service to postpone inoculations pending Federal release of poliomyelitis vaccine to continue the program.

The second dose of vaccine is effective even if given several months after the first dose. The third or booster dose is most effective if given six or more months after the second dose. This means that those first and second grade school children who have received their first inoculation should receive the second injection when the vaccine becomes available.

With unparalleled public support and cooperation over 110,000 first and second grade school children in Maryland have received the vaccine to date."

The above is submitted to you for your information.

Very truly yours,

Huntington Williams, M.D.

Commissioner of Health

STATE OF MARYLAND DEPARTMENT OF HEALTH

MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, June 3–30, 1955

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCUS	MUMPS	POLIOMYELITIS, PARALYTIC	POLIOMYELITIS, NON-PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS: Influenza and pneumonia
Total, 4 weeks																			
Local areas																			
Baltimore County	10	—	16	—	15	—	19	6	1	—	8	—	—	1	19	1	3	—	3
Anne Arundel	3	—	1	—	5	—	—	—	—	—	3	—	—	3	7	1	7	—	1
Howard	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Harford	2	—	1	—	1	—	—	—	—	—	1	—	—	—	6	—	1	—	—
Carroll	1	—	—	1	—	—	5	—	—	—	4	—	—	—	—	—	—	—	—
Frederick	—	—	—	6	59	—	13	1	—	—	5	—	—	—	1	—	13	—	—
Washington	—	—	—	—	1	—	1	—	—	—	—	—	—	—	12	—	5	—	1
Allegany	4	—	—	2	—	—	2	—	—	—	20	—	—	—	1	—	—	—	1
Garrett	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	2
Montgomery	14	—	3	18	37	—	5	—	—	1	12	—	—	4	11	—	1	—	1
Prince George's	13	—	1	1	22	1	1	3	—	—	3	—	—	6	4	—	—	—	—
Calvert	1	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	3	—	—
Charles	—	—	—	—	—	—	3	—	—	—	—	—	—	—	1	—	—	—	1
Saint Mary's	6	—	—	—	2	—	3	—	—	—	3	—	—	—	3	—	—	—	—
Cecil	—	—	—	1	1	—	—	—	—	—	—	—	—	—	4	—	—	—	—
Kent	—	—	1	—	2	—	—	—	—	1	—	—	—	—	—	—	1	—	1
Queen Anne's	—	—	1	—	—	—	1	—	—	—	—	—	—	—	1	—	5	—	1
Caroline	—	—	—	—	—	—	2	—	—	—	—	—	—	—	1	—	2	—	—
Talbot	—	—	—	—	—	—	—	1	—	—	—	—	—	—	2	—	—	—	—
Dorchester	3	5	—	—	—	—	4	—	—	1	—	—	—	—	2	—	2	c-1	—
Wicomico	1	—	—	—	—	—	1	—	—	—	3	1	—	—	1	1	4	—	—
Worcester	1	—	—	—	—	—	3	—	—	—	—	—	—	—	1	—	1	—	—
Somerset	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—
Total Counties	59	5	24	29	145	1	63	11	1	3	62	1	0	14	79	3	57*		12
Baltimore City	60	0	21	1	53	1	71	3	3	1	15	0	0	14	94	14	585		12
State																			
June 3–30, 1955	119	5	45	30	198	2	134	14	4	4	77	1	0	28	173	17	642		24
Same period 1954	77	3	27	124	884	1	291	3	1	8	71	1	0	50	207	10	541		28
5-year median	238	1	63	—	570	3	238	3		5	69	3	3	47	214	18	580		25
Cumulative totals																			
State																			
Year 1955 to date	2007	8	406	222	1215	19	1275	26	5	10	2099	3	0	225	1028	87	3563		354
Same period 1954	2885	7	254	604	11037	22	2503	7	1	13	1222	7	3	426	1130	86	3556		318
5-year median	2923	15	570	—	4845	44	1786	13		9	1077	13	15	308	1322	138	3426		367

c = congenital syphilis under 1 year old.

* = total includes 8 from the migrant labor survey.

Blue Cross - Blue Shield

A MEDICAL STUDENT LOOKS AT BLUE SHIELD*

WILBUR C. PICKETT, JR.†

The medical student of today finds his chosen profession in a dynamic state. Major social, economic and political changes in recent years have had large effect in the medical field. The story of Blue Shield is in large measure the story of these changes and the adjustment of the medical profession to them.

The great depression centered national attention upon problems of individual security. Social security legislation illustrated the possibility of utilizing the sovereign powers of state or nation in the attempt to alleviate personal distress affecting large numbers of people. A climate of political experimentation made inevitable the advancement and advocacy of various proposals for the socialization of medicine.

The necessity for some concerted plan for dealing with the problems of medical costs had been suggested in the report of a five year study by a Committee headed by Dr. Ray Lyman Wilbur, a past president of the American Medical Association and then Secretary of the Interior in the cabinet of President Hoover. The majority report recommended that medical costs be financed through insurance or taxation or by such methods in combination.

A most significant development in the attitude of the medical profession toward the problem of medical costs occurred in September 1938 when the House of Delegates of the American Medical Association endorsed the principle of voluntary health insurance. This endorsement was the first of its nature. It occurred during a special session of the American Medical Association. It set the stage for a voluntary health program that has been called the greatest cooperative health effort in world history and it occurred at a time when the power of the profession to control the economic pattern of medical practice was being seriously questioned.

The choice of the profession of voluntary medical prepayment plans as a means of adjustment to changing conditions was probably, as Cunningham suggests,[1] attributable to the phenomenal success of the community-wide non-profit Blue Cross plans for hospital care that originated at Baylor University in Dallas, Texas, in 1929.

The first physician sponsored prepayment plan to follow the 1938 American Medical Association endorsement of voluntary insurance was established by the California Medical Association on a non-profit basis in 1939. The Michigan State Medical Society followed the California group with a similar plan in 1940 and shortly afterwards other state and county medical societies adopted similar prepayment plans and what has subsequently become known as the Blue Shield Plan was under way. The Plan represents an association of voluntary, non-profit, medically sponsored, medical care prepayment plans. The tremendous expansion of Blue Shield is reflected in the fact that in 1941 there were eight Blue Shield Plans with a total of 370,000 members, whereas by the end of 1953 there were 77 plans with 28,150,000 members.[2]

The success of the Blue Cross and Blue Shield programs is attributable in large part to the fact that in addition to acquiring large membership within themselves they catalyzed a voluntary health insurance movement that surpassed the success of any previous insurance program in history. Only in the wake of their success did commercial insurance companies awaken fully to the possibilities of the medical care market. Today Blue Shield plans write about 33% of the surgical insurance and 47% of the medical coverage; commercial plans account for 60% of the surgical insurance and 39% of the medical care insurance. Perhaps the best measure of the success that the voluntary plans have had in removing the economic barriers to medical care is reflected in the fact that

* Reprinted with permission from the Blue Shield Commission.

† The author is a third-year student at the University of Maryland Medical School whose essay won first prize in the national Student American Medical Association—Blue Shield Essay Contest. Mr. Pickett's entry was under the sponsorship of the Maryland Medical Service and the Maryland Chapter of the SAMA.

approximately 100,000,000 Americans have enrolled in hospital or medical prepayment and insurance plans.[3]

Thus Blue Shield is the effective answer of organized medicine to a great and challenging socio-economic problem—the problem of how best to meet the cost to the individual of serious medical emergencies. The problem is as old as civilization but the ever-changing complexities of social organization give it a constantly new appearance and require that any plan for coping with it be flexible and subject to adjustment to the specific conditions of time and place. Blue Shield has the merit of that great quality.

The basic concept is that of insurance which involves what Sir Winston Churchill has called "the magic of averages applied to the salvation of the multitude." It is but natural and logical that any expansion of this principle should be applied to protect the individual against the loss of capital or credit or both as a result of illness. The conditions of its application, however, require much thought.

The problem of how best to utilize the principle is essentially one for resolution by the medical profession because, despite the intrusion of social and economic considerations of a non-medical nature, the only comprehensive knowledge of the factors of controlling significance in any feasible plan is possessed by the medical profession. Quite obviously no other profession or group has had comparable experience with illness, its causes, costs, cures, and effects. The whole interplay of human relationships in respect to illness—actual, feigned, or anticipatory—is under the constant observation of the medical profession to a degree not even approximated by any other body of men.

It is for this reason, chiefly, that the medical profession—almost as a unit in this country—has rejected the concept of governmental responsibility for individual medical costs. The concurrence of other professions and groups, fortified by the adverse experience of those nations which have tried it, supports the view of the medical profession in this country that the occasional advantage to an individual of socialized medicine is much more than offset by its individual and group disadvantages.

All of the visualized values of socialized medicine—which have led to its adoption in some countries, such as England—can be realized through the wise employment of the related, but definitely distinct, concept of group responsibility through voluntary insurance without the sacrifice of those principles which have made America pre-eminent in the field of modern medicine.

The challenge to the medical profession implicit in the support of socialized medicine by influential persons and groups in this country is of especial interest to those of us who are medical students. The practitioners of tomorrow must come from our group and therefore we must expect to cope with the same basic problem and seek to carry forward the policies dictated by the experience and the judgment of our predecessors and elders.

Blue shield has been built on principle and proved by experience. It is no criticism to say that some experimentation—with resultant failure as well as most encouraging success—has been necessary in the past or that future experimentation may be required in the effort to achieve maximum success. Some degree of experimentation with proper attention to the safeguards dictated by experience, principle and judgment is essential to progress in almost any field.

Medical men, because of their awareness of the problem of the potentially adverse effect of medical costs to the individual and their clear and full realization of the total non-desirability of socialized medicine as an attempted solution of the problem, are morally obligated to use all of the resources of the profession to see that acceptable methods of dealing with the entire problem are successful in the widest possible area and the highest possible degree.

One of the areas yet to be explored fully relates to the fixing of the point at which the advantages of early diagnosis as the result of examinations induced by insurance—which would not be made otherwise—may be offset by excessive or unwarranted demands for medical attention induced by the same factor. An insurance plan or contract can not change human nature and there will always be individuals who are perverse as well as those who are merely unfortunate, but fortunately the principle of insurance rests on the laws of probability with respect to a group rather than the individuals comprising it. Thus it may be possible through safeguards yet to be devised to embrace the risks deriving from defects of character or judgment in

the process of insuring against the costs of illness and minimizing its incidence. After all, bonding companies do survive. Certainly in any event it will be possible ultimately to determine with reasonable accuracy the point at which insurance ceases to be feasible.

The vast increase in recent years in the total volume of insurance for the prepayment of medical and hospital costs has been a most significant and desirable social development. Undoubtedly it has lessened the demand that would otherwise have existed for solution of the problem by political means. There can be no doubt either that the medical profession through its sponsorship of various Blue Shield plans has contributed enormously to the accomplishment of what has been done, both directly and indirectly. And it may be that the contribution made indirectly by forcing competitive plans of other sponsorship to provide wider coverage and more liberal protection will prove in the long run to have been the more important effect.

The over-all success of Blue Shield is undoubtedly attributable to its insistence upon certain uniform conditions based on principles. Adhering to these principles and cautiously proceeding with the pioneering efforts to bring larger areas of medical costs within the protection of insurance, it is reasonable to anticipate a substantial solution of the entire problem.

1. Cunningham, R. M., Jr., The Story of Blue Shield, The Public Affairs Committee, Inc. 1954.
2. Ibid.
3. Public Relations in Medical Practice, James E. Bryan, p. 215. Williams and Wilkins, Baltimore, Maryland, 1954.

Ancillary News

PHARMACY SECTION

DR. ROBERT H. RILEY—A GREAT HEALTH ADMINISTRATOR*

JOSEPH COHEN†

Recently there appeared in the press a statement of profound interest to everyone in Maryland concerned with the high standards which prevail throughout public health administration in our state. I refer to the fact that Dr. Robert H. Riley has tendered his resignation as director of the Maryland State Department of Health, to become effective January, 1956.

This resignation takes on real significance when Dr. Riley's vast contributions to better health in Maryland are kept in mind. Indeed, in no state has the director of health assumed such prestige as that which Dr. Riley so properly enjoys. He became a member of the Maryland State Health Department in 1914, and director of the department in 1928.

Shortly after it became known that Dr. Riley had tendered his resignation, the following editorial appeared in the *The Sun* March 20, 1955:

"Dr. Robert H. Riley's decision to retire as director of the State Department of Health at the end of the year is little short of a decision to eliminate a monument, close an office, or end an era. For years and more years Dr. Riley *has been* the State Department of Health.

"This fact was given recognition ten or so years ago by no less a body than the Legislature. Dr. Riley's name was written into law as the permanent director of his department. Now Dr. Riley has taken the law into his own hands and decided to step aside.

"Dr. Riley's decision comes at a particularly special moment. A subcommittee of the State Committee on Medical Care has just finished a study of the State Department of Health and its widespread activities.

"Virtually the full credit for the State's outstanding achievement in public health work is placed at the door of Dr. Riley. Maryland was one of the first States to create public health groups on a county level and it was the first State to have a health group in each of its counties. Dr. Riley's service here was notable.

"The subcommittee has suggested that the State Health Department and, particularly, the State's participation in local health programs, be reorganized and brought into order. It holds that the time has come to end the personalized operations which grew up and flourished so well under Dr. Riley.

"There is no lack of appreciation in these proposals for the work which has been done by the present director. There is merely a recognition that times are changing and that a more precise order must prevail if the State Health Department is to go ahead as rapidly in the long-range future as it has done in the past.

"Fortunately for the man who takes Dr. Riley's place, there will be on call for advice and help the man who has been the Health Department—Dr. Riley."‡

Some added appreciation of Dr. Riley's tremendous career is afforded by a brief statement with

* A radio broadcast over Station WFBR, Sunday, April 2, 1955. Submitted April 7, 1955 for publication in the MARYLAND STATE MEDICAL JOURNAL.

† Executive Secretary, Maryland Pharmaceutical Association.

‡ Reprinted by courtesy of *The Sun*.

respect to the make-up of the Maryland State Department of Health. Membership on the State Board of Health, under whose authority the Department is conducted, is shared by medicine, dentistry, sanitary engineering, and pharmacy. Among the distinguished men who have served as members of the Board are Dr. William H. Welch, Dr. Thomas S. Cullen, Dr. John S. Fulton, Dr. E. F. Kelly, and others.

Dr. Welch was one of the "big four" who established the Johns Hopkins Medical School, and whose efforts in behalf of medical progress made it the most distinguished medical school in the world. For many years, Dr. Welch served as a member of the State Board of Health, and regarded his membership on it as one of his great civic and professional distinctions.

Dr. Thomas S. Cullen was the greatly beloved professor of obstetrical surgery at the Johns Hopkins Medical School, and for many years was virtually an institutional figure in the medical and public life of the State.

Dr. E. F. Kelly served as a member of the State Health Department from 1920 until the date of his death in 1945. He was a distinguished pharmaceutical educator, and an internationally renowned member of the pharmaceutical profession.

Dr. John S. Fulton was the first director of the Department, and was profoundly versed in all matters involved in public health administration.

These four names are mentioned in this manner in this broadcast to indicate the manner, or the type of men who, over the years, have served Maryland in this highly important official capacity. While the *Sun* editorial does give a good appraisal of Dr. Riley and his work, much more needs to be said in order to really appreciate his contributions to public health.

As a director of the Department, Dr. Riley supervised many activities authorized and required under state law. In addition, he supervised many additional duties in cooperation with various health agencies of the federal government. I mention this fact, because it is indicative of the broad coverage which the State Health Department is required to give to health matters.

In addition to its work in vital statistics, contagious diseases, dental hygiene, sanitary engineering, food and drug regulation and control, pre-natal and post-natal care for mothers, infant care, the Department maintains extensive laboratories in chemistry, pharmaceutical chemistry, bacteriology, industrial wastes, and other fields in which modern science plays a part.

It is necessary to have some grasp of the depth and breadth of the Department in order to understand the part it plays in health administration and also of the quality of work and personnel demanded for its proper and effective functioning.

In addition to the extensive laboratories maintained at the Department's headquarters in Baltimore, branch laboratories are maintained in different parts of the State in order to make their services closely available to physicians for diagnostic and other essential health services.

Of particular interest, as we give attention to Dr. Riley's career is the success of his effort to provide full-time health services in each of the 23 counties of the State and also to have full time, adequately trained health officers in each of these counties. This is a monumental achievement, and it should be a matter of pride to all of us that Maryland was the first state to inaugurate such a system.

Having expertly qualified health officers, each of whom is a physician, gives the State Health Department intimate contacts with the health conditions as they exist in every locality and it also affords the Department available personnel to deal with any public health hazard in its most incipient stage. The reports which these health officers send into headquarters and the health data which they assemble on a completely up-to-date basis, gives the Department that kind of information and control which has been so largely beneficial in giving the people of our State such enviable health conditions.

As pharmacists, we have the highest respect and admiration for Dr. Riley, and know from first hand knowledge of the constructive impact which his career has had on public health administration in this State. One of the functional divisions of the Department is under the direction of an official, Dr. L. M. Kantner, who bears the title of Chief of Division of Drug Control. This division maintains, day in and day out, close ties with retail pharmacy, manufacturing pharmacy, the wholesale drug business, and serves in a cooperative capacity with the federal Food and Drug Administration.

In this work, the inspection of retail drug stores runs into several thousand each year, which is another way of indicating the interest which the Department manifests in the availability and quality

of professional pharmaceutical service. The inspector assures himself that the drug store is under the immediate and personal supervision of a registered pharmacist and that all aspects of the store are carried on in conformity with the appropriate State law.

This inspection service is of the greatest public significance when it is borne in mind that the number of prescriptions filled annually in Maryland drug stores exceeds five million. When we bear in mind the character and purpose of the prescription, we see the utter necessity of seeing to it that this professional service is restricted to competent and expertly qualified pharmacists.

The Department, also through its Division of Drug Control, purchases several thousand specimens of drug products each year, and these are all subjected to chemical analysis in the laboratories of the Department. Such specimens are obtained from retail drug stores, manufacturing plants, wholesale drug houses, and it is through this procedure that the Department maintains accurate and dependable records with respect to the quality, purity and dependability of the drug products used by physicians and purchased for home use.

Reference above was made to the cooperation of the Department through its Division of Drug Control, with the Federal Food and Drug Administration. This has proven very beneficial in excluding unsatisfactory drug products from our State. Under this cooperative arrangement, the Food and Drug Administration calls to the attention of the Maryland authorities any unsatisfactory drug products made in this State and sold in other states.

In other words, when the Federal agency finds unsatisfactory drug products which were made in Maryland, but which have moved in interstate commerce, it gives the facts to the Maryland authorities and this provides the basis for regulatory action by the Division of Drug Control.

Whenever the inspectors of the Division of Drug Control find unsatisfactory drug products on sale in Maryland, but which were manufactured in some other State, the facts are called to the attention of the Federal Food and Drug Administration, thus providing it with the basis for regulatory action under the Federal Food, Drug, and Cosmetic Act.

A mere statement of this reciprocal system of regulation and control is sufficient to show the practical value of the cooperation which exists between the Food and Drug Administration and the Division of Drug Control of the Maryland State Department of Health.

By way of summary, it can be stated that the career of Dr. Riley as director of the Maryland State Department of Health has been one of superlative value to the people of our State. Not only has he been alert to every health hazard which could occur, but he has been equally alert to ways and means of alleviating the conditions from which such hazards might evolve. He has been particularly mindful of the need for rigid milk control, the maintenance of high standards of sanitation and hygiene throughout the State.

He has been particularly interested in maintaining public water supplies free from contamination of all kinds. He has been instrumental in having sewage disposal plants built in every municipality where health conditions so demand. He has played a major role in the progressive improvement in the treatment and care of tuberculosis patients and it was through his leadership that legislation was enacted requiring all hospitals in the State to operate under permits issued by the State Health Department as a means of assuring their compliance with proper hospital administration standards.

As pharmacists, we have always regarded Dr. Riley as a highly qualified authority in the field of public health administration and as a public servant whose life has been one of dedication and devotion to the public welfare. All of Maryland owes him a debt of gratitude for his splendid professional services in behalf of better health for all our people.

As pharmacists, we are happy to join the *Baltimore Sun* in wishing him many years of happy, contented, and useful retirement, as certainly these are his by every right of service and duties well and faithfully performed.

Some Examples of Interference with Profession

Treaty provisions have injected themselves into some medical areas, and under present law they constantly threaten greater interference. Licensure is one example. Until 1923 treaties of friendship and commerce did not attempt to deny states the right to bar aliens from medical and other professional practice. But in 1923 the United States entered into a treaty with Germany that established a new policy on state laws and regulations. For the first time it applied "national treatment provisions" specifically to the professions. This forbids states to bar a person from the practice of medicine solely because of his alienship. In subsequent years nine treaties carrying this "national treatment provision" were ratified. During 1951–1952, three additional treaties with provisions on the practice of professions were submitted to the Senate. Because of mounting objections to the alien provisions, the Senate delayed confirming these treaties. In 1953 the Senate Foreign Relations Committee concluded: ". . . If a state by its own constitutional processes required that an individual seeking to practice a particular profession should be a citizen of the United States, such laws should not be nullified by the national treatment provisions." Subsequently, the committee recommended to the Senate that no treaty carrying the "national treatment" clause be extended:

". . . to professions which, because they involve the performance of functions in a public capacity or in the interest of public health and safety, are state-licensed and reserved by statute or Constitution exclusively to the citizens of the country . . ."

The State Department has agreed to put this reservation in future treaties. So, for the time being, no new treaties will override state licensure provisions, but the older treaties will do so. *It should be remembered that this is a "gentlemen's agreement," and that it can be terminated at any time.* It is the feeling of the AMA that a more permanent form of safeguard is required. Putting this "gentlemen's agreement" into law would not be the answer, as a later law or a later treaty would take precedence and could restore the alien's right to equal consideration.

Nineteen states have constitutional or statutory provisions of long standing requiring that to practice certain professions a person must be a United States citizen. Fourteen states require first papers, and ten do not accept foreign-trained physicians.

Also held in abeyance, but not permanently disposed of, is an international agreement that could impose a system of national compulsory health insurance on this country. This is the International Labor Organization's Convention on Minimum Standards of Social Security.

The Convention, adopted by the ILO in 1952, covers nine fields: medical care, sickness benefits, unemployment benefits, old age benefits, employment injury benefits, family benefits, maternity benefits, invalidity benefits and survivor benefits. A government is considered to have ratified the Convention if it promises to meet the requirements in three fields.

The medical care section stipulates that a country may qualify as ratifying if it agrees to provide one of the following: a system of compulsory health insurance; private, voluntary health insurance "administered by public authorities under established regulations" set by law; or private, voluntary health insurance administered by insurance companies but under government "supervision." Half the population would have to be covered.

In June, 1954, the State Department forwarded this document to Congress, but with the recommendation that no action be taken, inasmuch as most points were within the jurisdiction of states. *Here again, this is not a threat for the time being, but only because of the attitude of present Congress and the present Administration.* Another Congress or another administration could push for the ratification of this treaty that could impose a certain degree of socialized medicine without enactment of any domestic law. The treaty is hanging in suspension; it will never expire. It is the contention of the sponsors of the Bricker amendment that protection against this and similar treaty abuses must be established permanently in an amendment to the Constitution.

NURSIN

M. RUTH MOUBRA

SCHOOLS OF NURSIN

Programs approved by the Maryl

SCHOOLS OF PR

General educational requirements: Graduation from an accredited high school. The following courses should be included: English—4; plete 16 credits.

The commercial course is usually acceptable if the applicant has the foregoing credits. Most schools waive specific requirements for Many schools of nursing accept students who have passed the comprehensive examinations administered by the Maryland Sta

Entrance

School of Nursing	City	Religious Denomination	Type of Nursing Program		Length of Program
			Diploma	Degree	
Bon Secours Hospital	Baltimore	Catholic	X		3 years
Church Home & Hospital	Baltimore	Episcopal	X		3 years
Franklin Square Hospital	Baltimore	Non-sectarian	X		3 years
The Johns Hopkins Hospital[3]	Baltimore	Non-sectarian	X	X	32 mos., 2 yrs. colleg 36 months others
Lutheran Hospital of Maryland	Baltimore	Lutheran	X		3 years
Maryland General Hospital	Baltimore	Methodist	X		3 years
Mercy Hospital	Baltimore	Catholic	X		3 years
Mount Saint Agnes College[4]	Baltimore	Catholic		X	4 years
Provident Hospital (for negro students)	Baltimore	Non-sectarian	X		3 years
St. Agnes Hospital	Baltimore	Catholic	X		3 years
St. Joseph's Hospital	Baltimore	Catholic	X		3 years
Sinai Hospital	Baltimore	Non-sectarian	X		3 years
Union Memorial Hospital	Baltimore	Non-sectarian	X		3 years
University of Maryland	Baltimore	Non-sectarian		X	4 years
Memorial Hospital	Cumberland	Non-sectarian	X		3 years
Sacred Heart Hospital	Cumberland	Catholic	X		3 years
Memorial Hospital	Easton	Non-sectarian	X		3 years
St. Joseph College, Division of Nursing[5]	Emmitsburg	Catholic		X	4 years
Frederick Memorial Hospital	Frederick	Non-sectarian	X		3 years
Washington County Hospital	Hagerstown	Non-sectarian	X		3 years
Peninsula General Hospital	Salisbury	Non-sectarian	X		3 years
Washington Missionary College—Washington Sanitarium & Hospital	Takoma Park	Seventh Day Adventist		X	4 years

SCHOOLS OF PR

General educational requirements: Completion of elementary school or the e

Entrance R

School of Nursing	City	Religious Denomination	Type of Nursing Program	Length of Program
Anne Arundel General Hospital	Annapolis	Non-sectarian	Practical	1 year
Baltimore City Hospitals	Baltimore	Non-sectarian	Practical	1 year
South Baltimore General Hospital	Baltimore	Non-sectarian	Practical	1 year
University of Maryland (Division)	Baltimore	Non-sectarian	Practical	1 year
Cambridge-Maryland Hospital	Cambridge	Non-sectarian	Practical	1 year
Eastern Shore State Hospital	Cambridge	Non-sectarian	Practical	1 year
Crownsville State Hospital	Crownsville	Non-sectarian	Practical	1 year
Henryton State Hospital (for negro students)	Henryton	Non-sectarian	Practical	1 year
Rosewood State Training School	Owings Mills	Non-sectarian	Practical	1 year
Springfield State Hospital	Sykesville	Non-sectarian	Practical	1 year
Victor Cullen State Hospital	Cullen, Md.	Non-sectarian	Practical	7 mos. Victor Cullen; 5 mos. Wash. County Hosp.

[1] Submitted by Maryland League for Nursing.

[2] Information about accreditation of the professional schools of nursing by the National Nursing Accrediting Service should be ob-

[3] The degree of Bachelor of Science in Nursing is conferred by the Johns Hopkins University through the medium of McCoy College successfully a program of study at The Johns Hopkins Hospital School of Nursing.

[4] Students for the program in nursing at Mount Saint Agnes College receive their hospital experience at Mercy Hospital, Baltimore.

[5] Students for the program in nursing at St. Joseph College, Division of Nursing, receive their hospital experience at St. Agnes

ECTION

N., *Administrator*

N MARYLAND—1955[1]

le Board of Examiners of Nurses[2]

SSIONAL NURSING

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irements

Minimum Education	Age	Married Students Accepted	Classes Admitted	Approximate Total Cost to Students	Scholarships or Loans Available	Stipends Paid to Students	Men Students Accepted
H.S. grad.	17–30		September	$325.00			
H.S. grad.	17+(no max.)		Aug. and Sept.	$125.00	X		
H.S. grad.	17–35	X	September	$200.00	X		
H.S. grad.		X	September	$700.00 32 mos.; $800.00 36 mos.	X		If qualified
H.S. grad.	17–35	X	September	$250.00	X		
H.S. grad.	17–35		Feb. and Sept.	$165.00	X		
H.S. grad.	17–30		September	$320.00	X		
H.S. grad.	Not specified	Individual cases considered	September	$2,600.00 resident; $1,300.00 day	X		
H.S. grad.	18–35	X	September	$415.00	X		
H.S. grad.	17		September	$375.00	X		X
H.S. grad.	17–30		September	$300.00	X		If qualified
H.S. grad.	17–35	X	September	$273.45	X		
H.S. grad.	17–35	X	September	$450.00	X		
H.S. grad.; univ. admission	17–40	X	September	$2,231.00	(Limited number)		X
H.S. grad.	17–35	Individual cases considered	September	$285.00	X		
H.S. grad.	17–35		September	$310.00	X		
H.S. grad.	17–35	X	September	$150.00	X		
H.S. grad.	16–30		September	$3,000.00	X		
H.S. grad.	18–35		August	$250.00	X	X	
H.S. grad.	17–35		September	$250.00	X		
H.S. grad.	Not specified		September	$350.00	X		
H.S. grad.	17–35	X	September	$3,000.00	X		X

CTICAL NURSING

uivalent. Preference is given to applicants who have completed high school.

quirements

Minimum Education	Age	Married Students Accepted	Classes Admitted	Approximate Total Cost to Students	Stipends Paid to Students	Men Students Accepted
Completed 8th grade	18–40	X	Feb. and Sept.	$10.00	$25–$75 per mo.	X
Completed 8th grade	17–49	X	Feb. and Sept.	$10.50	$20.00 per mo.	X
2 years H.S.	17–40 with excep. to 50	X	Mar. and Sept.	None	$25–$75 per mo.	
H.S. preferred	18–50	X	Mar. and Sept.	$100.00	$50.00 per mo.	X
2 years H.S.	18–55	X	Jan. and Sept.	$12.00	$25.00 per mo.	
If under 25, H.S. or equiv. If over 25, 8th grade	over 18	X	September	None	$2,438 per year	X
2 years H.S.	18–45	X	Feb. and Sept.	None	$2,438 per year	X
2 years H.S.	18–45	X	Feb. and Sept.	None	$50.00 per mo.	X
2 years H.S.	17–40	X	September	$50.00	$2,160 per year	X
Completed 8th grade; H.S. preferred	18–45	X	Mar. and Sept.	$100.00	$2,438 per year	X
Completed 8th grade	18–45	X	Mar. and Sept.	None	$50.00 per mo.	

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upon women who complete at least two years of approved college work in an accredited institution of higher learning and then pass

Hospital, Baltimore and at Sacred Heart Hospital, Cumberland.

NURSING

M. RUTH MOUBRAY,

SCHOOLS OF NURSING

Programs approved by the Maryland

SCHOOLS OF PRO

General educational requirements: Graduation from an accredited high school. The following courses should be included: English—4; plete 16 credits.

The commercial course is usually acceptable if the applicant has the foregoing credits. Most schools waive specific requirements for Many schools of nursing accept students who have passed the comprehensive examinations administered by the Maryland Stat

Entrance R

School of Nursing	City	Religious Denomination	Type of Nursing Program		Length of Program
			Diploma	Degree	
Bon Secours Hospital	Baltimore	Catholic	X		3 years
Church Home & Hospital	Baltimore	Episcopal	X		3 years
Franklin Square Hospital	Baltimore	Non-sectarian	X		3 years
The Johns Hopkins Hospital[3]	Baltimore	Non-sectarian	X	X	32 mos., 2 yrs. college 36 months others
Lutheran Hospital of Maryland	Baltimore	Lutheran	X		3 years
Maryland General Hospital	Baltimore	Methodist	X		3 years
Mercy Hospital	Baltimore	Catholic	X		3 years
Mount Saint Agnes College[4]	Baltimore	Catholic		X	4 years
Provident Hospital (for negro students)	Baltimore	Non-sectarian	X		3 years
St. Agnes Hospital	Baltimore	Catholic	X		3 years
St. Joseph's Hospital	Baltimore	Catholic	X		3 years
Sinai Hospital	Baltimore	Non-sectarian	X		3 years
Union Memorial Hospital	Baltimore	Non-sectarian	X		3 years
University of Maryland	Baltimore	Non-sectarian		X	4 years
Memorial Hospital	Cumberland	Non-sectarian	X		3 years
Sacred Heart Hospital	Cumberland	Catholic	X		3 years
Memorial Hospital	Easton	Non-sectarian	X		3 years
St. Joseph College, Division of Nursing[5]	Emmitsburg	Catholic		X	4 years
Frederick Memorial Hospital	Frederick	Non-sectarian	X		3 years
Washington County Hospital	Hagerstown	Non-sectarian	X		3 years
Peninsula General Hospital	Salisbury	Non-sectarian	X		3 years
Washington Missionary College—Washington Sanitarium & Hospital	Takoma Park	Seventh Day Adventist		X	4 years

SCHOOLS OF PR

General educational requirements: Completion of elementary school or the e

Entrance R

School of Nursing	City	Religious Denomination	Type of Nursing Program	Length of Program
Anne Arundel General Hospital	Annapolis	Non-sectarian	Practical	1 year
Baltimore City Hospitals	Baltimore	Non-sectarian	Practical	1 year
South Baltimore General Hospital	Baltimore	Non-sectarian	Practical	1 year
University of Maryland (Division)	Baltimore	Non-sectarian	Practical	1 year
Cambridge-Maryland Hospital	Cambridge	Non-sectarian	Practical	1 year
Eastern Shore State Hospital	Cambridge	Non-sectarian	Practical	1 year
Crownsville State Hospital	Crownsville	Non-sectarian	Practical	1 year
Henryton State Hospital (for negro students)	Henryton	Non-sectarian	Practical	1 year
Rosewood State Training School	Owings Mills	Non-sectarian	Practical	1 year
Springfield State Hospital	Sykesville	Non-sectarian	Practical	1 year
Victor Cullen State Hospital	Cullen, Md.	Non-sectarian	Practical	7 mos. Victor Cullen 5 mos. Wash. County Hosp.

[1] Submitted by Maryland League for Nursing.

[2] Information about accreditation of the professional schools of nursing by the National Nursing Accrediting Service should be ob-

[3] The degree of Bachelor of Science in Nursing is conferred by the Johns Hopkins University through the medium of McCoy College successfully a program of study at The Johns Hopkins Hospital School of Nursing.

[4] Students for the program in nursing at Mount Saint Agnes College receive their hospital experience at Mercy Hospital, Baltimore.

[5] Students for the program in nursing at St. Joseph College, Division of Nursing, receive their hospital experience at St. Agnes

SECTION

R.N., *Administrator*

IN MARYLAND—1955[1]

State Board of Examiners of Nurses[2]

ESSIONAL NURSING

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H.S. grad.	18–35		August	$250.00	X	X	
H.S. grad.	17–35		September	$250.00	X		
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If under 25, H.S. or equiv. If over 25, 8th grade	over 18	X	September	None	$2,438 per year	X
2 years H.S.	18–45	X	Feb. and Sept.	None	$2,438 per year	X
2 years H.S.	18–45	X	Feb. and Sept.	None	$50.00 per mo.	X
2 years H.S.	17–40	X	September	$50.00	$2,160 per year	X
Completed 8th grade; H.S. preferred	18–45	X	Mar. and Sept.	$100.00	$2,438 per year	X
Completed 8th grade	18–45	X	Mar. and Sept.	None	$50.00 per mo.	

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Hospital, Baltimore and at Sacred Heart Hospital, Cumberland.

PLAN THIS AS PART OF YOUR VACATION

Semiannual Meeting—Ocean City, Maryland

MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND

Friday, September 16, 1955

Headquarters—Commander Hotel

Plan to attend and make your Hotel Reservations now.

STATE AND TERRITORIAL HEALTH OFFICERS INDORSE GRANTS PROPOSALS

The AMA Washington Letter 84-15

The Association of State and Territorial Health Officers is indorsing four of the six provisions of the administration's omnibus health bill. The association's position was presented to the House Interstate and Foreign Commerce Committee and the Senate Labor and Public Welfare Committee by Dr. J. W. R. Norton, association president. The letter made no mention of the association's position on the federal reinsurance fund for prepayment plans or federal mortgage insurance for building health facilities. In his letter Dr. Norton noted that ordinarily responsibility for health of persons in a state has rested with state and local health departments. "However, Congress has recognized that the federal government has a direct responsibility because of the role played by a constructive public health program in the matter of national military and civil defense and the prevention of the interstate spread of disease."

These portions of identical bills before the two committees were indorsed: (1) grants to increase numbers of practical nurses, (2) grants for improving the training of professional nurses for teaching and administration, plus traineeships for physicians and other public health personnel, (3) elimination of present categorical grant setup for public health work and lumping into three broad groups, (4) grants for new and current mental health programs in the states.